

# Life Events and Childhood Morbidity: A Prospective Study

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**ABSTRACT.** The relationship between family life events and rates of childhood morbidity was studied prospectively in a birth cohort of New Zealand children during the period from ages 1 to 4 years. Family life events were associated with increased risk of medical consultation and hospital attendance for illness of the lower respiratory tract, gastroenteritis, accidents, burns, scalds, and accidental poisoning. In addition, children from families experiencing large numbers of life events had an increased risk of hospital admission for suspect or inadequate care. The correlation between life events and rates of child morbidity persisted when a series of measures of family social and economic background was taken into account statistically. Possible explanations of the role of family life events in the development of childhood morbidity are discussed. *Pediatrics* 70:935-940, 1982; *life events, childhood illness, longitudinal study, social factors.*

A number of studies have examined the relationship between family life events and child health.<sup>1-10</sup> Although these studies have demonstrated significant associations between family life events and risks of childhood morbidity, the design of some studies has limited the significance of their results. These limitations have included the use of relatively small (30 to 100) samples,<sup>1-4</sup> examination of the effects of life events over short (one year or less) time periods,<sup>1-3,5</sup> or concentration on a single illness rather than the array of childhood illnesses that may be provoked by family life events.<sup>2-10</sup> In addition, some studies have evaluated only illnesses resulting in hospital admission,<sup>1,5</sup> without attention to any possible association between general practi-

tioner consultations or illness treated at hospital outpatient clinics, and the reported occurrence of family life events.

This paper reports the results of a three-year study of the relationship between family life events and risks of morbidity in a birth cohort of 1,082 New Zealand children aged from 1 to 4 years. The aims of the study were: (1) to describe the relationship between family life events occurring when the child is 1 to 4 years of age and rates of hospital and general practitioner attendance for illness of the lower respiratory tract gastroenteritis, accidents, burns and scalds, and accidental poisonings; (2) to adjust any apparent correlations between family life events and risks of childhood morbidity for the effects of a series of family sociodemographic factors: maternal age, maternal ethnic status, maternal educational level, family size, child's family placement at birth and at age 1 year, and measures of family living standards.

## METHODS

The data were collected during the first six stages of the Christchurch Child Development Study.<sup>11</sup> In this study a birth cohort of children has been studied at birth and at 4 months, 1 year, 2 years, 3 years, and 4 years of age. At each point information on the health, family conditions, and social background of the children has been collected by a structured interview with the child's mother supplemented by information from other sources. The medical history of the cohort was collected in the following ways.

## General Practitioner Information

**Maternal Diaries.** For the age periods 0 to 4 months, 12 to 24 months, 24 to 36 months, and 36 to 48 months, mothers were requested to keep a

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diary record in which they recorded all details of their child's history of medical contact during the next interview period. Compliance with the diary was moderately good: during the period from birth to 4 months of age 85% of mothers kept records; subsequent to this approximately 61% returned records.

**Maternal Recall.** Mothers were asked to recall incidents of illness since the previous interview. This was used to cross-check the adequacy of the diary record and for mothers who had not kept a diary. Questioning about illness involved a series of 26 precoded items which spanned various childhood illnesses.

**Direct Contact.** In cases in which maternal recall was obviously hazy and a diary record had not been kept, direct contacts were made with the general practitioner to obtain details. This involved either the mother telephoning her family doctor for details or in a few cases, the research group writing to the doctor. In all cases medical information about the child was released on the basis of signed maternal consent. To facilitate recording of information and maternal recall most mothers were contacted at least 24 hours before each interview and asked if they could attempt to recall their child's medical history before the interview. Thus, most mothers had at least a day to think about this topic before questioning took place.

### Hospital Records

The initial source of information on hospital admission and attendance came from maternal recall and the diary record as above. This was verified by obtaining hospital notes for each reported visit. Information was collected for all public hospital, private hospital, and Karitane hospital attendances. Case note information was obtained on the basis of signed consent from the mother.

It was possible to cross-check the reporting accuracy of mothers for a limited group of hospital admissions by checking the admission record and computer information at the Christchurch Public Hospital. This check revealed that the reporting of hospital admissions was accurate: during the four-year study period only five admissions were not reported and these were for trivial reasons. Inasmuch as admission to Christchurch Public Hospital accounted for more than 80% of the total admissions for the sample, it seems likely that the data collection process obtained almost complete information on the sample's history of hospital attendance.

Although this method of data collection does not guarantee complete certainty that all information about the medical history of the sample was recorded, the combination of maternal recall, diary

records, general practitioner contacts, and hospital notes probably provides a more systemic basis for measuring childhood morbidity than has been the case for other large-scale studies of childhood illness<sup>12-14</sup> which have usually been limited to one method of data collection and often have relied solely on maternal recall.

From the data base of this study the following measures were abstracted for analysis:

**Measures of Morbidity.** Rates (per 100 children aged from 1 to 4 years) of general practitioner consultation, hospital admission, hospital attendance (hospital admission plus hospital outpatient attendance), and total medical contact (hospital attendance plus general practitioner consultation) were determined for: (1) illness of the lower respiratory tract (bronchitis, bronchiolitis, pneumonia); (2) gastroenteritis; (3) burns and scalds; (4) accidental poisoning; (5) accidents other than burns, scalds, and poisoning (ie, lacerations, bruising, fractures, etc); and (6) suspect home-related conditions. This measure was an attempt to summarize the frequency of a series of uncommon but often related conditions reflecting the adequacy of the child's home. These included suspected child abuse, failure to thrive, and morbidity in which the child's condition was partially or wholly associated with inadequate home environment. The suspect home-related conditions measure was based on case note information derived from hospital records so the measure is available for hospital admissions only. Further, because the data could only be obtained from hospital records, they may provide a biased measure of the prevalence of such conditions.

The morbidity indices for analysis were selected on the basis of prior evidence suggesting their sensitivity to familial variations and because the frequency of their occurrence provided sufficient numbers of observations for analysis.<sup>11</sup>

**Life Events Score.** This was based on a modified version of the Holmes and Rahe Social Readjustment Rating Scale<sup>15</sup> and consisted of 20 items which covered such areas as death or illness in close family members, changes in parents' employment, financial problems, and marital disharmony. The scale items and the percentage of mothers endorsing each item each year are shown in Table 1. A life events score was computed by summing the number of life events reported during the period the child was aged from 1 to 4 years. The maximum life events score was 60. The Kuder-Richardson formula 20 reliability estimate for the scale was 0.72.

**Family Social Background Factors.** The following factors were considered: (1) maternal age; (2) maternal ethnic status; (3) maternal education level; (4) family placement at birth: one-parent family/natural two-parent family/adoptive family; (5)



TABLE 1. Item Endorsement Rates for (Modified) Holmes and Rahe Social Readjustment Rating Scale

| Item                                                             | % Endorsing Each Item |          |          |
|------------------------------------------------------------------|-----------------------|----------|----------|
|                                                                  | Year 1-2              | Year 2-3 | Year 3-4 |
| Moved house                                                      | 27.7                  | 22.8     | 22.6     |
| Husband changed job                                              | 22.6                  | 16.4     | 19.3     |
| Started new job (respondent)                                     | 19.6                  | 16.9     | 20.1     |
| Serious/prolonged disagreements with parents/inlaws              | 8.1                   | 8.0      | 7.1      |
| Death of close friend/relative                                   | 24.5                  | 21.2     | 24.9     |
| Increased financial problems from taking on mortgage or business | 11.2                  | 8.0      | 6.7      |
| Husband became unemployed                                        | 4.4                   | 4.1      | 5.9      |
| Serious financial problems                                       | 9.5                   | 7.3      | 6.1      |
| Serious/prolonged arguments with husband/ex-husband              | 12.2                  | 8.5      | 7.8      |
| Divorce/legal separation from husband                            | 3.0                   | 3.4      | 3.1      |
| Reconciliation with husband (after divorce/legal separation)     | 1.0                   | 0.6      | 0.8      |
| Problems with sex                                                | 11.8                  | 5.7      | 3.7      |
| Assault by husband                                               | 3.2                   | 2.6      | 2.0      |
| Serious illness or accident (respondent)                         | 7.4                   | 9.5      | 8.6      |
| Serious illness or accident (husband)                            | 6.6                   | 6.7      | 6.3      |
| Serious illness or accident (child other than survey child)      | 4.7                   | 6.0      | 5.7      |
| Serious illness among other family members                       | 22.7                  | 17.2     | 16.9     |
| Pregnancy                                                        | 27.9                  | 27.6     | 20.4     |
| Respondent involved in court case                                | 5.5                   | 4.1      | 2.9      |
| Husband involved in court case                                   | 6.1                   | 4.2      | 5.1      |

family placement at age 1 year: one-parent family/two-parent family/adoptive family; (6) family size (the number of siblings when the child is 1 year of age).

*Measures of Family Living Standards (at Age 1 Year).* These were derived from a factor-analytic study of the material conditions of the child's home.<sup>16</sup> This analysis identified two general dimensions of family material conditions, one relating to the level of ownership of consumer durables and the other to the amount of hardship or economizing the family faced in key areas relating to food, clothing, and medical care. Both scales were of moderate to good reliability and showed systematic correlations with a variety of concurrent and predictive validity measures.

#### Response Rates and Treatment of Missing Data

The response rates for the four-year study period are shown in Table 2. The rates are expressed first, as a percentage of the original sample of the 1,265 children in the study and second, as a percentage of the original sample of 1,265 children who are still

alive and residing in New Zealand. The sample at age 4 years represented 89.1% of the original sample of 1,265 children and 96.2% of those alive and residing in New Zealand.

The results of this study are based on a sample of 1,082 children for whom all data were available for the four-year study period. This number is less than the 1,127 children interviewed at age 4 years as some children were not studied at all interview periods.

#### RESULTS

The rates (per 100 children aged from 1 to 4 years) of hospital admission, general practitioner consultation, hospital attendance, and total medical attendance for illness of the lower respiratory tract, gastroenteritis, accidents, burns and scalds, accidental poisonings, and suspect home-related conditions, by life events are shown in Table 3. There is a general trend for morbidity rates to increase in almost direct proportion to the number of family life events. Specifically, children from families experiencing 12 or more life events had, on average, six times the risk of hospital admission compared with children from families with three or fewer life events. This differential reduces for hospital attendance (three times the risk of morbidity) and for general practitioner consultation (1.7 times as many consultations). The general trends are summarized in the total medical contact score: on average, children in families experiencing 12 or more life events had 2.1 times the risk of medical attendance compared with children from families with three or fewer life events. In all cases the associations between life events and rates of morbidity were highly statistically significant.

To take account of the effects of variations in family social background and family material well-being on the apparent correlation between family life events and childhood morbidity, a series of regression analyses was performed in which rates of hospital admission, hospital attendance, general practitioner consultation, and total medical contact were adjusted for the effects of maternal age, maternal ethnic status, maternal educational level,

TABLE 2. Response Rates During Four-Year Study Period

| Time | No. Interviewed | % of Original Sample (N = 1,265) | % of Those Alive and Residing in New Zealand |
|------|-----------------|----------------------------------|----------------------------------------------|
| 1 yr | 1,180           | 93.3                             | 96.9                                         |
| 2 yr | 1,156           | 91.4                             | 96.6                                         |
| 3 yr | 1,143           | 90.4                             | 96.2                                         |
| 4 yr | 1,127           | 89.1                             | 96.2                                         |

TABLE 3. Morbidity (per 100 Children Aged 1 to 4 Years) by Life Events Score

| Measure                                                | No. of Life Events |                |                 |                |
|--------------------------------------------------------|--------------------|----------------|-----------------|----------------|
|                                                        | 0-3<br>N = 288     | 4-7<br>N = 462 | 8-11<br>N = 216 | 12+<br>N = 124 |
| General practitioner consultation                      |                    |                |                 |                |
| Lower respiratory tract illness                        | 41.11              | 37.39          | 68.37           | 55.00          |
| Gastroenteritis                                        | 13.94              | 12.61          | 16.74           | 18.33          |
| Accidents                                              | 36.93              | 55.87          | 50.23           | 65.83          |
| Poisoning                                              | 2.44               | 5.22           | 5.58            | 12.50          |
| Burns/scalds                                           | 12.20              | 19.78          | 6.05            | 27.50          |
| Total                                                  | 106.62             | 130.87         | 146.97          | 179.16*        |
| Hospital admission                                     |                    |                |                 |                |
| Lower respiratory tract illness                        | 1.39               | 1.30           | 0.46            | 7.26           |
| Gastroenteritis                                        | 2.78               | 1.73           | 2.31            | 4.84           |
| Accidents                                              | 0.69               | 3.25           | 4.17            | 7.26           |
| Poisoning                                              | 1.04               | 2.16           | 4.17            | 8.87           |
| Burns/scalds                                           | 0.35               | 1.08           | 0.46            | 2.42           |
| Suspect home-related conditions†                       | 1.39               | 0.22           | 0.46            | 13.71          |
| Total‡                                                 | 7.64               | 9.74           | 12.03           | 44.36‡         |
| Hospital attendance (admissions and outpatient visits) |                    |                |                 |                |
| Lower respiratory tract illness                        | 6.25               | 6.28           | 5.56            | 24.19          |
| Gastroenteritis                                        | 2.78               | 1.73           | 2.78            | 6.45           |
| Accidents                                              | 34.72              | 48.48          | 46.30           | 66.94          |
| Poisoning                                              | 6.25               | 7.58           | 14.35           | 24.19          |
| Burns/scalds                                           | 8.33               | 15.80          | 17.59           | 49.19          |
| Total‡                                                 | 58.33              | 79.87          | 86.58           | 170.96‡        |
| Total medical contact                                  | 164.95             | 210.74         | 233.55          | 350.12‡        |

\*  $P < .005$ .

† This measure available for hospital admissions only. See "Methods."

‡  $P < .0001$ .

TABLE 4. Statistics for Life Events by Morbidity Measures of Regression When Social and Familial Factors Are Included in Regression

| Measure                           | <i>r</i> | $\beta$ | <i>F</i> | <i>P</i> | Other Significant Factors<br>( $P < .05$ ) |
|-----------------------------------|----------|---------|----------|----------|--------------------------------------------|
| General practitioner consultation | .12      | .13     | 16.82    | <.0001   | Birth placement                            |
| Hospital admission                | .18      | .16     | 24.42    | <.0001   | Birth placement                            |
| Hospital attendance               | .15      | .12     | 14.10    | <.0001   | ...                                        |
| Total medical contact             | .18      | .17     | 28.23    | <.0001   | Birth placement, maternal education        |

family size, child's family placement at birth and at age 1 year, and measures of family economizing and family ownership. These adjustments were achieved using ordinary least squares regression on a square root transformation of the rate data.

For each morbidity measure, the bivariate correlation between the family life events score and rates of morbidity, the corresponding standardized regression coefficient ( $\beta$  weight), the associated  $F$  statistic, and level of significance are shown in Table 4. For each morbidity measure, the effect of adjustment for family social background and family living standards was negligible, with the life events score remaining highly statistically significant in each case.

## DISCUSSION

This three-year prospective study shows clearly that family life events were associated with increased risks of illness of the lower respiratory tract, gastroenteritis, accidents, burns and scalds, accidental poisonings, and hospital admissions for suspect home-related conditions. For individual measures of morbidity, the associations between life events scores and risks of morbidity were not large, but when the data were aggregated over a range of conditions that were sensitive to family life event variations, large differences emerged: children whose mothers had experienced 12 or more life events during the three-year period had rates of



hospital admission for one or more of the above conditions that were six times higher than those children whose mothers had experienced three or fewer life events and rates of total medical attendance that were more than twice as high. This result shows that the net effect of life events on child health was large, even though for specific types of morbidity, only relatively small differences were present. This implies that future research in this area should perhaps concentrate more on the effects of life events on child health and well-being in general and less on the effects of life events on the risks of specific types of morbidity.

It is perhaps worth noting that this study was based on a reduced version of the Holmes and Rahe Social Readjustment Rating Scale (SRE) and that other alternative measures for measuring family life events for preschool children have been proposed by Coddington.<sup>17</sup> Whether the Coddington measure would produce evidence of stronger correlations than the reduced version of the Social Readjustment Rating Scale here is open to question but it should be noted that both measures contain a number of similar items (eg, death of parent, marital discord, changes of residence, etc).

Multivariate analysis showed that the apparent correlations between life events and child health remained virtually unchanged when the data were controlled for the effects of a number of familial and social factors including maternal age, maternal ethnic status, maternal education level, family size, the child's family placement at birth and at age 1 year, and family living standards. This result shows that the tendency for child health to be associated with life events cannot be explained as arising from the effects of common familial and social factors.

The tendency for a series of measures of child health to vary with life events independently of family and social background could be explained in at least two ways. First, it might be suggested that the presence of stress in the child's family decreases maternal coping ability with a resultant decrease in child rearing standards and a consequent increase in risks of childhood morbidity. Alternatively, it may be that the effects of stress in the family are a direct alteration of the child's susceptibility to illness. It seems likely that both factors may be involved. Meyer and Haggerty<sup>3</sup> have shown changes in levels of child health associated with life events in which the increased risk of morbidity appears to reflect a change in the child's susceptibility to illness rather than a change in child rearing patterns. The mechanisms that mediate the correlation between family life events and increased susceptibility to childhood illness are not clear although a variety of factors including decreased immunoglobulin (Ig)A

levels and increased catecholamine secretion may be involved.<sup>18-23</sup>

However, other correlations between life events and child health are less easily explained in this way. In particular, the persistent correlations found between risks of accidents, burns and scalds, and accidental poisonings and life events<sup>4-10</sup> strongly suggest that increased risks of accidents may be due to the fact that stress reduces maternal vigilance and this is associated with increased risks of accidents of various types.<sup>24</sup>

Finally, the results of this study tend to reinforce the well recognized pediatric dictum that in many cases of childhood morbidity it is as important to treat the family and its general problems as it is to treat the child and his specific symptoms.

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## INPATIENT STATISTICS AT THE HÔPITAL DES ENFANTS MALADES IN PARIS FOR THE YEAR 1822

The Hôpital des Enfants Malades, the world's first children's hospital, was founded in Paris in 1802.<sup>1</sup> Twenty years later it contained 560 beds, 491 for medical and 69 for surgical patients.

In 1822, 2,641 patients were admitted; their diagnoses were as follows:

| Acute diseases   | Boys | Girls |
|------------------|------|-------|
| Medical          | 819  | 777   |
| Surgical         | 209  | 87    |
| Smallpox         | 51   | 42    |
| Chronic diseases | Boys | Girls |
| Scrofula         | 51   | 16    |
| Tinea            | 46   | 56    |
| Scabies          | 304  | 153   |

The overall mortality among inpatients was about 27 percent. The mortality for smallpox was 47 percent, and for measles 35 percent.

Contrary to current practice in our children's hospitals, inpatients at the Hôpital des Enfants Malades, at least in 1822, were hospitalized for exceedingly long periods. For example, patients with scabies spent between 21 and 69 days in the hospital; for tinea the average hospital stay was 156 days; and for scrofula 288 days.<sup>2</sup>

Noted by T.E.C., Jr, MD

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# The Teaching of Crisis Counseling Skills to Pediatric Residents: A One-Year Study

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**ABSTRACT.** Pediatric residents should learn to manage family crises such as informing parents that their child has a potentially life-threatening illness. Unfortunately, few training programs prepare residents to counsel parents of a child with cancer. An experiential parent crisis counseling program has been developed at the Children's Hospital National Medical Center in Washington, DC; this program has demonstrated that pediatric residents, with limited instruction, can be taught to give bad news to parents using effective information-giving and interpersonal skills. *Pediatrics* 70:907-911, 1982; *interpersonal skills, residency training, crisis counseling.*

At no time is effective communication more critical than when the pediatrician is conveying the diagnosis of a potentially fatal illness in a child to the parents. The impact of such a traumatic event forces many parents to turn to their physicians for counsel and comfort. Many physicians, unfortunately, are unable to meet the parents' needs and concerns on a personal level or to help the parents adjust emotionally and cope successfully with the impact of the devastating news. Thus, an impasse often is reached in which the expectations of the parents exceed the service that the physician is able to render.

Problems in communication among doctors and patients or parents of a child with fatal illness are well recognized.<sup>1-4</sup> The Task Force on Pediatric Education found that more than half of young pediatricians rated their residencies as providing

insufficient experience with psychosocial and behavior problems.<sup>5</sup> Further, it was found by the Task Force that pediatricians need to acquire interpersonal skills and become competent in counseling in order to manage such family crises as life-threatening illnesses and death. The American Cancer Society (1979) has expressed concern over the lack of physician-patient communication skills. The Society recommends that an improvement be made in the way in which the cancer patient and his family are informed by the physician of a diagnosis of cancer; they further recommend that greater consideration be given to the psychosocial impact of the diagnosis.

A review of the literature reveals that the training and postgraduate education of physicians has focused mainly on the technical aspects of medicine. The rapid technologic and scientific advancements in medical care over the past 50 years have eliminated many serious and fatal diseases and have extensively improved the quality of health care. These achievements have also contributed to the increasing mechanization and dehumanization of medical care and the changing of the physician-patient relationship. However, the significance of the physician-patient relationship has been recognized only recently and consideration given to provide instruction in interpersonal and communication skills in the training and education of future physicians.<sup>6-8</sup> Most of this training has been in history taking and interpersonal skills and has occurred mainly in the preclinical years.<sup>6</sup> Further, most literature focuses on training physicians to obtain information; there has been little instruction in information-giving and counseling skills that physicians must employ with parents and patients to help them effectively cope with a potentially fatal illness.<sup>9</sup>

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In response to this need, a crisis counseling program was developed by the Office of Medical Education with the Department of Hematology/Oncology at Children's Hospital National Medical Center in Washington, DC to give second- and third-year pediatric residents an opportunity to develop and enhance their information-giving and counseling skills with parents of a child with a potentially fatal illness. This paper describes the results of a study of this instruction program using simulated parents and video-taped replay as an instructional methodology.

## METHODS

This study, conducted at Children's Hospital National Medical Center (CHNMC) in Washington, DC, involved 24 second- and third-year pediatric residents rotating on medical units where pediatric oncology patients were clustered or on a Hematology/Oncology elective between November 1980 and June 1981.

The primary goal of the instructional program was to enhance the quality of pediatric medical care by increasing the competency of pediatric residents in their second and third years in crisis counseling skills with parents whose child faced a potentially fatal illness. The project had three major objectives: (1) to provide instruction to the residents in critical information to discuss with the parents during this first interview; (2) to provide instruction and give feedback to the residents on interpersonal and communication skills that enhance their effectiveness in crises interactions with parents; and (3) to evaluate the parent crisis counseling instructional program's effectiveness as a means of improving information-giving and interpersonal skills.

## Procedures

The Crisis Counseling Program consisted of a brief orientation at the beginning of the rotation/elective, a one-hour lecture presented by an oncologist on important aspects of childhood leukemia or a comprehensive handout summarizing this information, and two 1½-hour parent crisis counseling instructional sessions. The orientation was a brief overview of the Crisis Counseling Program, including background of the program, a review of program objectives, and the administrative details of the program.

The instructional sessions consisted of 1½-hour parent crisis counseling feedback sessions. The first session took place in the first week of the rotation/elective after the orientation and the lecture whereas the second session was in the last week of the rotation (fourth week). Each session included

the resident being video-taped in a 30-minute session while informing "simulated" parents that their child had leukemia. (A different set of parents was used for each session.) Following the 30-minute sessions, the simulated parents, who were professionals in counseling, spent one hour with the resident providing feedback about his/her information-giving and counseling skills via checklists and a review of the video tape. The components of the instructional sessions were as follows:

*Component 1: Crisis Counseling Interview (30 Minutes).* The resident, while being video-taped, is allotted 30 minutes to counsel simulated parents who have learned one of two histories typical of a child with acute lymphocytic leukemia (ALL) and the responses commonly made by parents to this type of family crisis.

*Component 2: Self-Assessment and Instruction (55 Minutes).* In the ten minutes immediately following the interview, the resident filled out a checklist (available upon request from the authors) and scored it with a template to provide immediate feedback on the proportion of critical information he or she imparted to the parents. "Critical" information was determined from the responses to a survey of 118 oncologists throughout the United States and 31 parents whose children's disease had been diagnosed as leukemia and who had been treated at CHNMC asking what information they considered "critical" to give parents during the first interview in which the diagnosis of acute lymphocytic leukemia is presented (same case histories were used with oncologists as with residents). The responses of the parents and physicians were significantly related ( $r .83$ ;  $P < .001$ ). During this time the simulated parents each completed a checklist (available from the authors) which identified their feelings during the session and a second checklist in which they rated the clarity of the information that the resident imparted.

During the remaining 45 minutes the resident and the simulated parents reviewed the checklists and the video tape of the 30-minute counseling session, pausing to discuss aspects of the resident's behavior that elicited or failed to elicit important information and feelings.

*Component 3: Evaluation (Five Minutes).* Five minutes before the end of the session, the parents and the resident completed an evaluation form, rating the importance and effectiveness of the session's objectives and commenting on strengths of the session as well as how it might be improved.

The components of these sessions were essentially the same. However, the instruction was the independent variable with the dependent variables being the resident's performance on the "critical" information checklist, the clarity of critical infor-



## Interpersonal Skills

The second objective of the Crisis Counseling Program was to provide instruction and give feedback to the residents in interpersonal skills (trust, communication, compliance) to enhance their effectiveness in crisis interactions with parents. These skills were evaluated by studying the amount of positive and negative feelings in the parents which were elicited by the resident during the video-taped interview. The impact of the instruction on the positivity of the parents' feelings, as measured by a trust and feelings checklist based on Gibb's model of trust in interactions,<sup>10</sup> was measured.

The results of the first resident-parent crisis counseling interview (prior to instruction) revealed that 68% (15/22) of the residents were rated as having an overall acceptable positive level of interpersonal skills. Three weeks following the instruction, 19 of the 22 residents (86%) were reported to interact at an overall acceptable positive level. The other three residents whose interpersonal skills were not at an acceptable level during the second interview, had extremely high ratings in the first

**TABLE 2.** Clarity of Residents' Discussion of Essential Information as Rated by Parents\*

|                                 | Pre-instruction | Post-instruction |
|---------------------------------|-----------------|------------------|
| All residents (N = 22)          | 3.3             | 3.6              |
| Residents who improved (N = 15) | 3.0             | 3.8              |
| Residents who declined (N = 7)  | 4.0             | 3.2              |

\* Rated on five-point scale as follows: 5, information discussed appropriately; 4, information discussed close to appropriately; 3, information, mentioned, but not clear.

**TABLE 3.** Direction of Change in Residents' Interpersonal Skills After Instruction

| Direction of Change | No. of Residents                                                                                             |
|---------------------|--------------------------------------------------------------------------------------------------------------|
| Positive            | 11 (50%) at acceptable level                                                                                 |
| No change           | 7 (32%) at acceptable level                                                                                  |
| Negative            | 4 (18%) (3 started extremely high and went to unacceptable level; 1 declined but stayed at acceptable level) |

**TABLE 4.** Residents' Ratings of Program

|                     | Instruction on Information-Giving Skills |           | Instruction on Interpersonal Skills |           |
|---------------------|------------------------------------------|-----------|-------------------------------------|-----------|
|                     | Session 1                                | Session 2 | Session 1                           | Session 2 |
| Extremely effective | 5 (28%)                                  | 4 (22%)   | 9 (50%)                             | 4 (22%)   |
| Very effective      | 9 (50%)                                  | 10 (56%)  | 7 (39%)                             | 11 (61%)  |
| Effective           | 4 (22%)                                  | 4 (22%)   | 2 (11%)                             | 3 (17%)   |
| Not very effective  | 0                                        | 0         | 0                                   | 0         |
| Ineffective         | 0                                        | 0         | 0                                   | 0         |

interview (Table 3). Mothers and fathers reported support to the trust and acceptance of the residents; in addition, skills, which they felt reassured and they felt they were listening, can also to by the residents, and that they were part of second finding of team in the treatment process. The instruction through many of the appeared to have the most impact on the residents' level of listening skills (only 13 were at an acceptable level (most had prior to instruction and 20 reached an acceptable communication skills level after instruction) and encouraging parents' autonomy, two who feel a part of the team in the treatment process. Most residents made positive gains, and 20 residents were at an acceptable level after instruction).

## Residents' Responses to Program

Following each instructional session, residents were asked to rate the "effectiveness" of the session. Parents in accomplishing the objectives of providing management of the instruction on: (1) essential information to be given responding to the parents during the first session and (2) interpersonal skills which enhance their interaction with parents in crisis counseling.

All residents rated the instruction in both information-giving and interpersonal skills in crisis counseling, it was found to be "effective," "very effective," "extremely effective" (Table 4). No one rated their study program as "ineffective." In addition, all residents, following both sessions, rated the program as "highly applicable" (63%) or "applicable" (38%) to their present work and future careers.

## DISCUSSION

The results of this study suggest that residents can learn, in a limited time, more effective information-giving and communication skills with parents of a child with a potentially fatal illness. The study indicated that residents significantly ( $P < .05$ ) improve in the quality and quantity of information conveyed to the parents after participating in one instructional feedback session. Residents, after this one session, were able to discuss a substantial portion of the "critical" information with the parents during the second interview, and, in addition, most residents improved in the clarity with which they discussed this information. The literature gives evidence that information-gathering skills can be taught to physicians.<sup>7,11-13</sup> This study



lends support to the hypothesis that information-giving skills, which are critical to effective patient management, can also be effectively taught.

A second finding of interest in this study is that, although many of the residents were at an overall acceptable level of interpersonal skills prior to instruction (most had participated in a history-taking communication skills program in their first year of residency), two important skill areas needed improvement. Most residents, after instruction, improved their skills to an acceptable level in these two areas: listening to the parents and enlisting the parents' active participation in the child's treatment process. Both of these interactional skills are highly important to the success of the crisis counseling encounter. Parents play an integral part in the management of the child with ALL, and listening and responding to their needs and concerns facilitates the treatment process. Furthermore, it has been found that parental compliance with pediatricians is directly related to the parents' satisfaction with the medical encounter.<sup>14</sup> Integral to satisfaction, it was found, is trust, reassurance (relieving anxiety), and making the parents feel competent. Our study points out that these skills, which encourage parent compliance, can be taught.

A few residents declined in their information-giving and interpersonal skills during the second interview. Variables that may have contributed to this negative change in performance include fatigue, interference with other responsibilities, and personality differences with parents. Although these are tangible issues that could have affected the interactions in this study, these issues represent a reality which physicians must recognize and consider to deal effectively with their patients.

Many residents reported being anxious about the video taping; in many instances this could be attributed to prior negative experiences in medical school where as medical students they were provided with minimal feedback and/or no subsequent opportunities to improve upon their performance. In our study, residents have reported the constructive feedback to be useful in their second interview and the study results support their reports.

Immediately following the instructional session residents indicated that this program would be highly applicable to their present work as well as their future careers. In actual application to their present work, a number of residents anecdotally reported that the program helped them in their

interactions with parents, not only concerning leukemia but with other problem or crisis encounters. The Task Force on the Future of Pediatric Education cited a priority need for residents to learn to manage family crises such as chronic illness and death and bereavement, by helping parents and children cope with their psychological reactions to physical illness and its treatment.<sup>5</sup> The results of this study indicated that programs such as this one can effectively address the need cited by the residents and the Task Force. Although the research funds for this project have been exhausted, the Office of Medical Education and the Department of Hematology/Oncology are committed to ensuring the continuation of this program.

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# Prevention of Children's Psychosocial Disorders: Myth and Substance

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**ABSTRACT.** A critical appraisal of primary prevention of children's psychosocial disorders indicates that our knowledge on this topic is limited and that there are few interventions of proven value. Nevertheless, there are possibilities for effective prevention. Myths associated with unwarranted claims for the value of prevention are reviewed in terms of unproven assumptions that: (1) prevention cuts costs; (2) prevention in childhood will improve adult health; (3) improved living standards will reduce mental illness; (4) sensible interventions can only be beneficial; (5) providing people with information leads to preventive action; (6) the main issue in prevention is implementing what we know; (7) the best approach is to tackle the basic cause; and (8) the crucial issue is to identify that one basic cause. Principles of causation are discussed and a model of causative influences is used to consider potentially effective primary prevention policies with respect to those directed at (a) individual predisposition; (b) ecologic factors; (c) influences on opportunity and situation; and (d) current stresses and strengths. It is concluded that a good deal is known about risk factors and the areas in which primary prevention might be effective, but that less is known concerning precisely how to intervene in order to bring about the desired results. There is a potential for effective primary prevention but, so far, it remains largely unrealized. *Pediatrics* 70:883-894, 1982; *primary prevention, child psychiatric disorder, ecology, evaluation, principles of causation.*

helpful enterprise that it is usually portrayed to be? In his essay on meddling Lewis Thomas<sup>1</sup> took a rather skeptical view. He argued:

Intervening is a way of causing trouble . . . Whatever you propose to do, based on common sense, will almost inevitably make matters worse rather than better. You cannot meddle with one part of a complex system from the outside without the almost certain risk of setting off disastrous events that you hadn't counted on in other, remote parts. If you want to fix something you are first obliged to understand, in detail, the whole system . . . Even then, the safest course seems to be to stand by and wring hands, but not to touch.

That sounds both destructive and discouraging and it contrasts starkly with the present great enthusiasm for prevention and the general feeling that appropriate and early psychosocial interventions ought to have a lasting beneficial influence on mental health and social functioning. But is this so, and are we yet in a position to advocate major preventive programs? Is the notion of effective prevention a myth or does it have substance? Critical appraisals of preventive policies have generally concluded that our knowledge on primary prevention is extremely limited and that there are very few interventions of proven value.<sup>2-7</sup> Nevertheless, also they emphasize that there are possibilities for effective prevention.

## PROBLEMS IN PRIMARY PREVENTION

There are several key problems in carrying out successful primary prevention. First, there is a considerable gap between the identification of a damaging factor and knowledge on how to eliminate or reduce its effect.<sup>8</sup> Thus, it has long been clear that severe family discord puts children at an increased risk for conduct disorders and delinquency. But it is quite another matter to know what can be done to increase family harmony. Second, with but few exceptions, short-term improvements in a chroni-

To most people it seems obvious that prevention must be a good thing, and it is no surprise that the literature is full of books and articles with ringing phrases urging that more be done in the field of prevention. But how much do we really know about prevention in the field of psychosocial disorders of childhood? And is it necessarily the benign and

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cally depriving situation will rarely have long-term benefits.<sup>9</sup> To be effective in influencing ultimate levels of development, either the interventions must involve a lasting change (as is the case, for entirely different reasons, with both immunization and adoption), or the improved experiences will need to be available throughout the child's period of growth. The very best of summer camps for preschool children cannot be expected to have any substantial long-term benefits. Third, even when an effective measure is available, there may be problems in ensuring that it reaches all target populations. For example, effective means of contraception have been available for some years and their use has undoubtedly led to major changes in patterns of family building. On the other hand, there has been much less success in reducing unwanted births among teenagers.<sup>5</sup> Fourth, although for the most part "critical periods" of development do not exist, and thus it's never too late to intervene, nevertheless patterns of disadvantage and failure once established tend to persist. Accordingly, there is a need to start interventions early in children's lives.

Last, all programs of prevention must take into account the cost-benefits ratio.<sup>7</sup> This requires an assessment of the importance of the behavioral disorder that they are meant to influence; the likelihood of the measure making a real difference; the number of people who can be reached by the method of intervention; the disadvantages that come as side effects (almost no effective intervention is free of these); political and ethical considerations (such as the loss of personal freedom in the imposition of remedies); and the cost of the preventive measures in terms of finance, resources, and personnel. With these considerations in mind, before discussing the various possibilities of action that are open to us, let me consider some of the myths (or at least unproven assumptions) about prevention.

## MYTHS

### "Prevention Cuts Costs"

The first myth is the economic argument that necessarily effective prevention will cut medical expenditure. At first sight, it seems self-evident that this must be so. If you prevent a disease, then the costs of treating it are eliminated. However, that argument assumes that there is a fixed number of illness episodes, and that if you could prevent one, no other will come to take its place. Experience with physical disease immediately indicates that this argument is false. We have been enormously successful in preventing a number of the killing infectious diseases of childhood but medical costs

have risen year by year. The point is that if people do not die of childhood illnesses, then they are likely to go on to suffer from many of the chronic illnesses of old age. No, we should not introduce prevention in the false hope that it will save money.

### "Effective Prevention in Childhood Will Improve Adult Health"

The next myth is in many ways an extension of the first—namely, the notion that effective prevention in childhood will in some way improve adult mental health. Although early actions may be of some long-term benefit, it is important to recognize that many adult mental disorders do not have their roots in childhood and also that if we remove one set of environmental hazards, another set may well come to take their place. Just as the elimination of smallpox in childhood has had no effect on cardiovascular disease in adult life, so the reduction of emotional disturbance in childhood may make no difference at all to, say, schizophrenia or manic depressive psychosis in adulthood.

### "Improvements in Living Standards Will Reduce Mental Illness"

The third myth is of a different kind. A common plea from social scientists or clinicians of liberal persuasion is for the nation to improve living standards in the expectation that this will improve mental health. This expectation is almost certainly false. Of course, we should work to eliminate poverty and to raise standards of housing, but that is because they are worthwhile goals in themselves, and not because their attainment will reduce rates of psychosocial disorder. But why is this a myth? Surely it is likely to help? After all, everyone knows that psychosocial problems of many kinds are much more common among the seriously deprived. Yes, indeed that is the case, but the causal inference is an uncertain one.<sup>5,6</sup> The association is based on cross-sectional data, and historical analyses give a rather different picture. In both Britain and North America there has been a major improvement in living standards during the course of the last 100 years. But these social gains have been accompanied by a worsening in many indices of disorder. Juvenile delinquency rates have increased greatly, and psychiatric conditions such as suicide and attempted suicide, anorexia nervosa, and alcoholism have also become more frequent among young people.<sup>5,6</sup> Unfortunately, the general expectation that raising living standards will improve mental health is misplaced. (It could be that the crucial feature is not the absolute level of affluence but rather the range of incomes or extent of inequality,<sup>10</sup> as there



has been little diminution in the disparities between top and bottom incomes over this century. However, few data are available to test that hypothesis.)

### **"Sensible, Humane Interventions Can Only Bring Benefits"**

The next myth is that sensible humane measures are bound to bring some benefits even if they do not eliminate the problem. Regrettably, that too is false. In the first place there are many basically sensible interventions that have proved to be of no benefit; for example, individual counseling as a means of preventing delinquency. From the original Cambridge-Somerville study<sup>11</sup> through the work of Tait and Hodges<sup>12</sup> to Craig and Furst<sup>13</sup> and others, this mode of intervention has consistently shown no benefits.<sup>6</sup> On the other hand, it may be argued that even if it did not help, at least it did not harm. But even that is not always the case. For example, there is some suggestion that the Cambridge-Somerville interventions may have had a slight effect in predisposing to a worse outcome,<sup>14</sup> and there are community-based behavioral treatments known to benefit delinquents but which are associated with an increased risk of delinquency when applied to predelinquents.<sup>15</sup> Or again there is the well known attempt by Cummings and Cummings<sup>16</sup> to educate a community in greater understanding and tolerance toward mental patients which seemed paradoxically to reduce acceptance of psychiatric disorder.

### **"Provision of Information on Risks Will Lead to Preventive Action"**

A further myth is that the provision of greater information concerning serious risks and hazards in itself will lead people to take appropriate preventive action. Would that were the case, but unfortunately often it is not.

There are several problems in this connection. However, one of the most important is that human behavior is not wholly rational and that a knowledge of risks does not necessarily mean that people will take the appropriate action to avoid the consequences. For example, although health information has had some effect on smoking by adults, most antismoking campaigns in secondary schools have been singularly unsuccessful.<sup>17,18</sup> Telling youngsters that smoking will lead to cancer many years later is not sufficient to cause them to stop smoking.

### **"Main Issue in Prevention Is Implementing What We Know"**

A commonly held belief, but one that constitutes a myth, is that the main issue in prevention is

implementing what we know. The implication is that a combination of apathy, political obstruction, and special pleading has stopped effective prevention from being carried out.<sup>19,20</sup> Clearly, there have been political obstructions of various kinds and it is important that these be dealt with. But the main problem is that in most instances we do not know what to do. This assertion of ignorance may seem to be a curious statement in the light of the vast increase in knowledge over the last half century which has led to a fairly good understanding of many of the major risk factors. But what we do not understand nearly so well is the mechanisms that underlie the statistical associations, and even when we do understand those mechanisms, we have a very poor knowledge of how to prevent the risk factor arising or having its adverse effect.<sup>8</sup> Indeed, there is a danger that we may precipitously rush into the wrong action just because we do not understand why something is a risk. The claim by the World Health Organization in the early 1950s<sup>21</sup> that day care inevitably caused permanent mental damage to children is an obvious case in point. The recommendation to eliminate day care was based on the increasing awareness that children could suffer from "maternal deprivation" and it seemed prudent to avoid these risks. The trouble arose from the false assumption that day care necessarily involved deprivation. As we know now, day care can be beneficial, neutral, or harmful in its effects depending on the age and other characteristics of the child, and on the quality and nature of the care provided.<sup>22,23</sup>

### **"Always Tackle the Basic Biologic Cause"**

A rather different myth is that it is always best to tackle the basic biologic cause, whatever that may be. Obviously, in the field of child psychiatry, there are many conditions that do not have a straightforward biologic cause of the kinds characteristic of internal medicine. But even when there is such a cause, it is not self-evident that it provides the best mode of intervention. For example, there are now many studies to show that children who suffer severe chronic malnutrition have impaired cognitive development.<sup>24</sup> It would seem obvious that the solution lies in feeding the children adequately so that their intellectual growth will proceed normally. Of course, it is desirable to feed the children. But what has been shown is that the provision of a better range of experiences and of personal interaction in the home may have at least as great an effect as the provision of food.<sup>24,25</sup> The point seems to be that malnutrition acts not only through direct effects on the brain (these do occur), but also in terms of the effects on interpersonal



interaction. Weak, sickly children tend not to get the sort of experiences they need.

### **"Crucial Issue Is to Identify the One Basic Cause"**

A further myth of a similar kind is that the crucial issue in prevention is the identification of the one basic cause of each disorder. Medicine teaches that there is a single basic cause for most conditions: the tubercle bacillus causes tuberculosis, and abnormalities in the production of insulin cause diabetes. The approach has paid off richly as the identification of specific causes has led to the development of specific remedies.<sup>26</sup> In psychiatry, too, it is likely that specificities of this kind may be discovered for some of the main disease states, although few examples have been found up to now. However, it is important to recognize that this is not the only causal question that can be posed.

### **"Principles of Causation"**

First, the notion of a basic fundamental cause often requires a rather arbitrary decision on what to regard as the beginning.<sup>5,9</sup> This may be illustrated by considering the syndrome of so-called "deprivation dwarfism." This is a condition found in young children who usually come from grossly disturbed families and who are of extremely short stature. At first it was thought that a lack of love impaired growth even when the intake of food remained adequate. This now seems not to be the case, at least in most instances. The answer is more humdrum: the children have not received enough to eat. To that extent, the dwarfism is "caused" by starvation. However, that leaves open the question of why the children had not been adequately fed. The answer often lies in parental neglect, or the child's depression following chronic stress. Therefore, it could be said that parental neglect or lack of love is the real cause. But that only puts the question back one stage further. Why did the parents neglect the child? The answer may lie in current social disadvantage or in adverse childhood experiences that failed to provide the proper basis for parenting. Are these then the causes? Or do we also need to ask why this child was deprived rather than his brother? Perhaps the answer to that question lies in his temperamental makeup or the fact that his birth had been unwanted. Of course, in a sense all of these variables are causes, and appropriate action requires an understanding of the process as a whole.

The second point is that multifactorial causation is the rule for most psychosocial disorders. Of course, to some extent that is true with medical

conditions generally. An example serves to emphasize how the most effective mode or point of intervention varies according to both the state of knowledge and the environmental circumstances. Tuberculosis is due to infection by the tubercle bacillus, and specific means of prevention and treatment are now available. However, malnutrition may also play a part in predisposition as shown by the fact that tuberculosis is still so common in parts of Asia and that it was rife in concentration camps during World War II. Improved standards of nutrition, and of public hygiene generally, might well do much to reduce susceptibility to tuberculosis if more specific remedies were not available; and even when they are available, a combined approach may be most effective of all.

The third point is that causation tends to be thought of in terms of the "who" question; that is, the reason why one person has a disorder or problem rather than another. That is a most important causal question. But it is not the only one, and in some circumstances it may not even be the most important. For example, we may need to ask the "how many" question.<sup>9</sup> The implications of the distinction are evident in the example of unemployment. The answer to the "who" question, ie, why this man is unemployed rather than that one, comes down to personal factors in large part. Those who are old, who lack work skills, who have chronic physical incapacities, or who show marked personality disorders are the ones most likely to be left without jobs. On the other hand, these factors have little or nothing to do with the "how many" question, eg, why the unemployment rate in many Western countries has risen so catastrophically over recent years. Here the answer is more likely to lie on the national or international economic situation, in political decisions, and in regional job opportunities. Whether the same applies in the mental health or social fields is uncertain. But, for instance, it may well be that the reasons why the delinquency rate has increased so much since World War II are different from the reasons why George becomes delinquent and Peter does not.<sup>6</sup>

The last point with respect to principles of causation is that in planning services it is not enough to know the reason why the disorders arise; we must also understand why they continue, and why they do or do not lead to functional impairment. For example, some 2.5% of the population are intellectually retarded insofar as they have a measured IQ < 70. But only some of these people require special schooling because of educational difficulties or failure; others cope satisfactorily in ordinary school classes. Many boys have a propensity to behave in disruptive or disturbing ways. But whether this actually results in vandalism, or



truancy, or scuffles in class depends on the school environment they experience.

It is evident that the concept of causation involves a variety of different processes and a range of points at which intervention may be effective (Figure). The types of causal processes may be summarized in the form of a model with four main headings: individual predisposition, ecologic or group predisposition, current stresses or supports, and the prevailing situation or opportunities.

Individual predisposition, may be shaped by genetic variables and by influences in the physical and psychosocial environment. Thus, in addition to hereditary factors as they apply to personality, intelligence, and mental illness, there are the effects of perinatal complications, postnatal trauma, or concurrent physical illness. But also, an individual's predisposition will have been influenced by the form of upbringing he has received—by the environment stresses and traumas experienced as a child, by the kind of love and discipline provided by his parents, by the values he has been taught, and by the social skills he has acquired.

Second, there is a different set of predisposing influences of a kind that apply to groups rather than to individuals. These may be subsumed under the general heading of ecologic predisposition. This would cover, for example, the effects of the social environment provided by schools. There is good evidence that children's behavior is strongly influenced by the ethos of the school they attend. Much the same applies to other social settings. Thus, young people's behavior is much influenced by the characteristics of the peer group of which they are a part,<sup>6</sup> and by the social role expectations relevant to the situations in which they find themselves. Also, under this same heading, there is a whole range of community and subcultural influences, together with the effects of the mass media, in increasing or decreasing the acceptability of particular forms of behavior.<sup>5,6</sup>

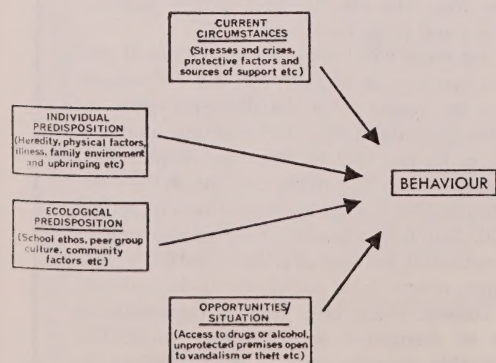


Figure. Simplified model of causative influences.

Third, a person's current circumstances must also be taken into account in terms of the stresses and supports for the individual. This heading would cover those acute life events such as the death of a parent, the loss of a job, a quarrel with a girl friend, or public humiliation at school which may precipitate depression or a suicidal attempt or an act of vandalism. Also it would include those protective factors and sources of support (such as good, confiding relationships at home, or the satisfactions and high self-esteem associated with accomplishments in school or on the sports field), that may enable the young person to survive the crisis and cope successfully with the life stresses he is experiencing.

Last, there is the situation or the opportunities prevailing at the time. Thus, a girl may have become depressed because of her genetic predisposition, her susceptibility as a result of attending a school in a disintegrating neighborhood in which morale is low and the precipitating influence of the death of her best friend in a road accident. However, whether this results in suicide may also be influenced by whether or not lethal drugs are readily accessible to her at the time. Similarly, whether a troubled teenager becomes an alcoholic will be influenced by the cost and availability of alcohol; and whether a potentially disruptive adolescent engages in vandalism may depend on his being in the vicinity of a poorly lit street with an empty building left unsupervised and already identified as being a suitable target by the existence of broken windows left unrepaired.

Of course, these four sets of variables are not truly separate. There are complex interactions between them. Nevertheless, they provide a convenient way of considering possible modes of preventive intervention.

### Last Myth: Possibilities of Prevention

The last myth is that we know so little that there is nothing we can do. There are dangers that ill-thought-out interventions may do more harm than good, and certainly there is a very considerable risk that we are going to promise far more than we can achieve. But these are reasons for caution and for thinking before we act, not reasons for not acting at all. Admittedly what we know is limited, but there are some things we can do now and it is our responsibility to see that the few effective interventions at our disposal are implemented.

### PREVENTIVE POLICIES DIRECTED AT INDIVIDUAL PREDISPOSITION

In the field of psychosocial disorders the aim of policies directed at individual predisposition has



usually been to provide some kind of experience that, it is hoped, will give the child strength to counter chronic stresses and disadvantages with which he/she has had to cope in growing up. There have been many unsuccessful attempts to intervene in this way. Nevertheless there are some things that can be done.

### **General Health Measures**

There is good evidence that young people with any form of organic brain dysfunction (such as cerebral palsy, epilepsy, or encephalitis) or with mental retardation have a much increased rate of psychosocial disorders.<sup>27,28</sup> Any measures that reduce the incidence of these conditions should have psychosocial benefits. In this connection there are a variety of actions that may be taken, but as most of these are well known,<sup>7</sup> I will not dwell on them here.

### **Prevention of Unwanted Births**

Children whose birth was not wanted by their parents, or who were born to teenage mothers, or who were brought up in single-parent households, or who grow up in very large families are all subject to a substantially increased risk of psychosocial problems. Much could be done to reduce the disadvantage experienced by all these groups, but also it is important to reduce the number of unwanted births. This is no straightforward matter. The free availability of family planning services is one important step but it is not enough. Those most likely to produce unwanted children (young single people and those with personal and social problems) are those least likely to avail themselves of services. Usually it is not that they positively wish to conceive a child or that they have ethical objections to contraception, but rather that their difficulty in planning a family is merely one facet of a general feeling of hopelessness and inevitability, or of a pervasive lack of foresight in planning all aspects of their lives. Conflicts over sexuality and sociocultural attitudes also play a part in the lack of use of services. For these reasons, family planning must form part of a wider community service that is educational in its broadest sense.<sup>5</sup>

### **Provision of Continuity in Good Quality Parenting**

Children who repeatedly go in and out of children's homes or foster homes or who live with their own parents in a severely unstable and unsettled family environment tend to have a high rate of psychosocial problems in adolescence. The same applies to young people who are reared in institu-

tions with multiple changing caretakers.<sup>29</sup> Those from a similar background who are adopted or who receive long-term fostering in an ordinary family environment are much more likely to develop normally.

Accordingly, in the case of young children whose parents seem unlikely even to look after them at all adequately, an early decision should be taken with respect to adoption or long-term fostering.<sup>5</sup> It is not in the child's interest for there to be vacillation and indecision while he shuffles to and fro from his parents into and out of foster care; nor is it in his interest to remain for long periods in an institution in the forlorn hope that the parents who abandoned him and who now only visit sporadically will one day take him back. Children require stability and continuity in parenting. It is important that their needs be paramount in such circumstances. Adoption is the one intervention in early childhood that really makes a major environmental change that is often of long-term benefit to the child. Obviously there must be stringent legal safeguards to ensure that children are not compulsorily removed from their parents without it being shown in court that this is a necessary step to ensure the child's well-being. As accurate knowledge on the likelihood of children being damaged by particular types of inadequate parenting is limited, there needs to be caution in advising that such removal is necessary. Also such removal should not take place (unless it is essential to preserve life), without strenuous and well-thought-out efforts made first to improve family circumstances and to help the parents in their task of child rearing. Such safeguards are essential both because of the great difficulties in making state provision of a quality that is up to even the average conditions in the ordinary family, and to protect parents from discriminatory intervention. Nevertheless it is not helpful for children to remain with parents who reject them, and cannot look after them properly, and who repeatedly give them up to foster care for short periods. In these circumstances it may be well to recognize that things are not going to improve and that it will be preferable for the child to receive long-term fostering to be adopted.

A related issue is the need to improve the quality of children's homes in order to meet the young children's psychosocial needs. It has proved possible to make residential nurseries for preschool children stimulating and interesting places with plenty of joint activities between staff and children. No longer need there be intellectual impairment associated with an institutional upbringing. However, it has proved much more difficult to ensure any kind of continuity in parenting. All too frequently the pattern is of a very large number of different and changing caretakers concerned with any one child



during the preschool years. This is not a pattern conducive to normal social development<sup>29</sup> and ways must be found to improve this aspect of institutional life for young children. Of course an institutional upbringing should never be a first choice, but regrettably it is likely that there will always be circumstances in which no other alternative is available. We should strive to find better ways of dealing with family breakdown, but also we must take steps to ensure that, for those children who experience it, being brought up in a children's home is as positive and beneficial in its effects as we can make it.

### Admission to Hospital

Repeated hospital admissions, especially in young children already experiencing chronic family adversity, is associated with an increased risk of psychosocial problems in later childhood and adolescence. Although the precise mechanisms whereby this leads to long-term disorder remain uncertain, a variety of steps can be taken to diminish the likelihood of psychological damage. These include, not only the provision of daily visiting or the opportunity for a parent to remain with the child during his stay in hospital and the improvement of conditions in the hospital itself,<sup>29</sup> but also various means of better preparing the child for hospitalization, as several controlled evaluation studies have demonstrated.<sup>30,31</sup>

### Day Care and Working Mothers

In recent years more mothers of young children have been going out to work, and more young children have been experiencing various forms of day care. Professionals have reacted to this trend in different ways, some wanting to reverse the trend by paying mothers to stay at home with their children and some wanting to meet the needs by a major expansion in the state's provision of day care facilities. Yet others have seen the need to bring fathers more into child care or to provide more part-time work for women. The available research data do not allow any empirical basis for a choice between these and other alternatives, although certainly it is clear that the quality of care is crucial.<sup>22,23</sup>

For that reason there is everything to be gained from efforts to improve children's experiences in day care facilities of all kinds, whether they be day care centers, day nurseries, play groups, nursery schools, or private baby-sitters. Thus it is important that there be continuity in the staff who care for the children, so that each child has only a limited number of primary caretakers. But also there needs to be a sufficient number of staff to provide the children with play and conversation, with an adequate range of experiences and learning opportunities. The second immediate need is to ensure that

the day care experiences enhance, rather than diminish, the parent-child interaction at home. This is not just a matter of including parents in the day care activities; this may not be possible with working parents, and indeed their presence at the central nursery may detract from their effective functioning if they are made to feel inexpert in contrast to the professionals looking after their children. Rather it is a recognition that day care should be viewed in terms of its effects on family life as a whole, and not merely as an experiential "input" to the child. Also it needs to be seen as an opportunity, if properly taken, to help parents better enjoy their children, understand their needs, and know how to play and talk with them. Many studies provide valuable leads on what may be done in this connection, but the merits and demerits of different approaches remain to be evaluated.

Three other areas of potentially effective prevention in relation to individual predisposition must be mentioned. It is well established that children being reared by mentally ill or criminal parents have a considerably increased risk of psychosocial problems. Much of the risk seems to stem from family difficulties, discord, and disturbance associated with the parental problems. Obviously, this provides an opportunity for preventive action but knowledge is lacking on how best to intervene effectively.

It is also well established that there are reasonably strong links between educational retardation and delinquency or other disturbances of conduct.<sup>6</sup> Although the mechanisms involved are both multiple and poorly understood, one factor seems likely to be the effect of severe reading difficulties in predisposing to emotional and behavioral problems through the experience of scholastic failure and its accompanying stigma. Insofar as that is the case, the effective prevention or remediation of reading and other scholastic difficulties should have psychosocial benefits, although this is yet to be demonstrated. Unfortunately, little is known about the best means of remedial treatment for children with severe reading retardation, and further research is much needed in this area.

It is obvious from all that I have said up to now that we should aim for an enhanced public awareness of children's needs, and that in particular we should do more to improve parental skills and sensitivities. Many parents fail to enjoy their children because they do not know how to play and talk with them; and discipline is a cause of strain and discord because parents set about it in the wrong ways. However, although that is generally recognized and accepted, there is considerable disagreement on just what to do about it. Clearly there is no one "right" way. The two most striking features of child care manuals over the years have been,



first, that professionals have usually expressed considerable certainty at any one time on the best method of child rearing, and second, that their recommendations change each decade or so. Rather than a "best buy" on the techniques to follow, it is a question of appreciating the implications of individual differences; of understanding the meaning of children's sensitivities and signals; of developing coping strategies of learning when to persist and when to desist; of monitoring what is done to see if it works, and if not, why not; and most of all, of maintaining harmonious relationships in the home with respect to the different personalities, and different ways of doing things in the family. How should that be accomplished? Several studies<sup>32-34</sup> have produced valuable leads but no well-tested general answer is available.

### ECOLOGIC INTERVENTIONS

Ecologic interventions constitute the second type of preventive measure. Human ecology refers to the study of the mutual interactions between man and his environment; it deals with systems rather than with individuals; and it is concerned with social groups in terms of their features as groups, rather than as unconnected individuals.<sup>5,35</sup> The implication is that groups have a life and force of their own that is both more than, and different from, the sum of the separate effects of the individuals in them. Ecologic interventions, in turn, are those that are best seen with respect to their impact on groups and the interaction of those groups within environmental settings. Perhaps the most obvious application of this approach is to schools, because they constitute social organizations with a recognizable boundary and purpose, and because research findings have shown that schools have important effects on young people's behavior and attainments.<sup>36</sup>

The first issue with respect to prevention possibilities arises from the observation that pupil outcomes tend to be worse in schools with a particularly high proportion of intellectually less able children. This is not just another way of saying that outcomes are usually less good for less able children (although obviously they are); but rather that for children of any level of ability outcomes tend to be less good if the bulk of the school population consists of children of below average intelligence. The implication is that there are considerable disadvantages in an educational system that allows such an uneven distribution of children that some schools have enrollments with a heavy preponderance of the intellectually less able. The findings point to the major drawbacks of either a community school system or an open market system. In the long term it is likely to be best when communities are sufficiently socially mixed so that community schools

would fairly automatically get a reasonably balanced enrollment. Socially deprived ghettos have many other disadvantages and, quite apart from the benefits of schooling, it seems highly desirable that towns be planned to avoid that development. In the shorter term, there is no alternative to local authorities maintaining a degree of control over admissions to school to ensure a fair parity between enrollments. So far as possible this should be done in keeping with parental and child choice. This cannot happen so long as some schools are markedly inferior to others. The most urgent requirement is to improve the quality of schooling generally, and especially to upgrade the worst schools. If this happens, parental choice is unlikely to work against the need to make enrollments of different schools comparable.

A further issue is that the skilled management of classroom groups constitutes a crucial element in successful schooling, and moreover, that schools vary greatly in the support and guidance provided to teachers. There is a need for better in-service training, in which probationary teachers observe their senior colleagues at work and benefit from the comments and advice of those who have observed them teach.

Third, there is the most crucial question of all with respect to schooling, that of implementing change and maintaining success. Given that we have a notion of some of the features that make for successful schooling (these concern the social ethos or climate of schools as well as improved teaching methods and approaches); what needs to be done to ensure that the right kinds of changes are brought about in schools that are currently experiencing difficulties? The issue is a complicated one and further research will be needed before we can have a really satisfactory set of answers.

The main bulk of evidence on schooling suggests that the benefits are most likely to come from improvements in the social organization of schools and classes as a whole—through the setting of appropriately high standards of behavior and work, the provision by teachers of good models of behavior, the opportunities for pupils to take responsibility and to participate in the life of the school, the ample use of praise and encouragements, harmonious teacher-pupil relationships, and a sufficient staff consensus on the values and aims of the school as a whole. However, there is the further question of whether there is merit in preventive programs specifically designed to foster mental health or to alleviate emotional/behavioral difficulties at an early stage. There are a few studies that offer promise of benefits from programs of this kind<sup>37,38</sup> but, others have shown a lack of effect<sup>39</sup> and, at present, it remains unclear whether these constitute a



worthwhile investment.<sup>6</sup> The matter warrants further investigation.

The idea of involving "the community" in preventive and therapeutic interventions of various kinds has become somewhat fashionable in recent years. There are now a handful of studies of various community development projects.<sup>6</sup> It is uncertain how much has been achieved in most of these, but certainly they include examples of constructive action. However, the ultimate value of this style of intervention remains to be determined.

There is good evidence indicating the importance of area influences in determining levels of child psychopathology.<sup>6,9</sup> In general, rates of problems tend to be high in inner city areas and lower in small towns. But there are exceptions to this tendency and it is not yet known what are the key variables.<sup>40</sup> Further research is urgently needed. The opportunity for primary prevention is undoubtedly present, but until the mechanisms or key variables can be identified, the opportunity for effective intervention remains potential rather than actual.

Various writers have argued that the concentration of high-risk families in any particular neighborhood affects the overall crime rate. In other words, a teenage boy from a high risk family is more likely to be delinquent if living in an area with a conglomeration of similar families than if he lives in a more mixed housing development. In fact, empirical data for adequate testing of these ideas are largely lacking.<sup>6</sup> It is apparent that the ways in which families with problems are distributed among neighborhoods may well influence the behavior of teenagers in those families; but there is a paucity of evidence on which to base policy recommendations. Nevertheless, the monitoring of natural experiments in terms of varying housing policy should provide both an answer and a guide to future housing policies.

There can be little doubt that, if skillfully employed, some types of propaganda can have sizeable effects on both attitudes and behavior (as shown for example by the success of sales campaigns in persuading mothers in developing countries to use powdered milk). It would be reasonable to suppose that it ought to be possible to harness this power in the interests of health education. However, the results up to now have been rather disappointing. The explanation almost certainly is not that the mass media cannot have an effect on the behavior of parents and children, but rather that we have not set about it in the right way.

#### PREVENTION THROUGH INFLUENCES ON OPPORTUNITY AND SITUATION

The field of prevention through interventions designed to affect opportunity and situation is one

which has been long been part of police thinking with respect to crime<sup>6</sup>; but up until recently it has played little part in thinking about psychiatric problems. However, it is probable that the approach is more relevant than has usually been appreciated.

For example, there is good evidence from historical trends that the cost of alcoholic drinks bears a strong relationship to the per capita annual consumption of alcohol, which in turn is strongly related to the extent of alcoholism and of alcohol-related diseases. There are many reasons for supposing that the correlation represents a causal link. As the general level of alcohol consumption increases, so does the proportion of the population who suffer from alcoholism rise in parallel. Of course, many factors will influence how much alcohol people will consume, but both economic influences (that is, through pricing) and formal controls (as through licensing) seem to play a part. There is a mass of evidence from data in many different countries that the price of alcohol is a major determinant of how much people drink. The implication is that if taxation is used to ensure that alcoholic drinks are relatively expensive, it is likely that this will limit the amount of alcohol that people consume, and this in turn will limit the extent of alcoholism. The evidence on the effects of licensing controls (such as those restricting the sales of alcohol to certain times, to certain stores, or to people above a particular age) is less clear-cut. It appears that major relaxations or tightening of controls probably do have some impact on alcohol consumption. For example, there was a 50% increase in alcohol consumption in Finland between 1968 and 1970 when extremely restrictive licensing controls were abruptly relaxed. Conversely, alcohol consumption in Britain fell by half during World War I when government restrictions were increased in an attempt to deal with the nation's lessened productivity that seemed to stem from excessive drinking. It is uncertain whether the growth of super-market sales of alcoholic drinks has encouraged their purchase as part of routine weekly shopping, and hence has increased consumption; but it may well have done so.

In much the same way, access to drugs is likely to be of some importance in relation to the levels of drug abuse, and of successful and attempted suicide, all of which have been increasing among children and adolescents.<sup>5</sup> The very substantial reduction in the toxicity of domestic coal gas in Britain led to a dramatic decrease in suicides due to coal gas poisoning, and in the population as a whole it probably also led to an overall reduction in deaths due to suicide. Since the early 1960s there has been a marked decrease in self-poisoning by barbiturates and a threefold increase in poisonings by psycho-



tropic drugs, almost certainly reflecting changing patterns of prescribing habits. The present extremely high rate of prescribing of drugs acting on the CNS may well make self-poisonings more likely, both as a result of potentially toxic drugs being left lying around in a large proportion of households, and through the creation of an attitude of reliance on drugs to solve personal problems. Moreover, the extent to which prescribed drugs kill if taken in excess may well constitute one factor that plays a part in deciding whether an attempted suicide becomes a completed suicide. The greater safety of many of the more modern drugs probably is an advantage in this connection. Steps to persuade doctors to reduce prescriptions to a more acceptable level and steps to increase the safety of drugs would likely be beneficial.

The availability of addictive drugs is also likely to be of importance in the spread of drug abuse. There is evidence that the rates of use and abuse of any particular drug depend on the availability of that drug. Moreover, strict drug legislation has been effective in some cases. Effective control of the availability of addictive drugs should help to limit drug abuse.

Not much evidence is available on the value of diversionary measures in relation to prevention. On the other hand, high delinquency areas are often those with a striking lack of leisure facilities; delinquency rates go up during periods when adolescents are out of school and have no organized activities; unemployed adolescents are particularly likely to become involved in crime. Although the benefits remain unproved, it is desirable that adequate leisure facilities should be available in all areas where young people live and congregate.

Examples of the protective efficacy of physical design features<sup>5,6</sup> include the marked reduction in car thefts brought about by steering wheel locks, and the limiting of telephone booth vandalism in Britain through the extensive strengthening of equipment. It is not known how generally effective protective measures of this kind are, nor is it clear how often they serve only to "displace" vandalism from one site to another. Clearly not much is likely to be gained if one part of a public area is made vandal resistant while the immediately adjacent area is left unprotected. However, there seems to be a strong opportunistic element in vandalism committed by adolescents, and if the opportunities are not readily available, damage may not take place.

Research has shown that vandalism tends to be less in schools in which the buildings are well maintained and the decorations are kept in good condition.<sup>36</sup> Adolescents seem more likely to cause damage to property that has already been damaged or

which appears abandoned or uncared for. There is an interesting report that when a London underground station that had been free of damage for many years had one ceiling panel broken, 30 more were broken in the following three weeks.<sup>41</sup> Satisfactory evidence is lacking, but the strong impression is that neglect leads to vandalism and that the rapid repair of damage may prevent further destruction.

Finally, under the general heading of influences and opportunity there is the crucial matter of surveillance. This is not just a question of supervision by police, caretakers, and the like. It is also clear that the role of the general public may be crucial.<sup>6</sup>

For example, there is the question of housing design. As Oscar Newman<sup>42</sup> put it,

"In a high rise building in which over a hundred families share an entry it is virtually impossible to distinguish neighbor from intruder or for anyone to attempt to enforce an acceptable mode of behavior or to feel comfortable about questioning the presence or activities of others."

The key physical variable seems to be the number of people involved in sharing a defined environment. The smaller the number of families sharing a facility, whether it's a demarcated portion of a project or the access and circulation space within a circumscribed portion of a multifamily building, the stronger are the feelings of possession, and ultimately of concern and responsibility. It should be appreciated that the main issue here is not space, although space helps, but design. High density neighborhoods can be built in a way that ensures that the streets and grounds are linked to specific dwellings (rather than left in the public domain), and that the building entries and accompanying space serve only a limited number of families.

There is also the separate issue of getting people in the community to take more interest and responsibility for the care of public facilities. In this connection there are some interesting examples of local efforts that appear to have been successful in reducing delinquency.<sup>5</sup> For example, there are several instances of contingency contracts in schools. There was one in Britain in which the pupils' side of the bargain was to keep the lavatories free of damage and graffiti for one summer term. In return, if they succeeded in doing that, Capital Radio would provide a disco. To most people's surprise, the scheme appeared to succeed. Or there is an example of a school in America in which the student body was provided with a set sum of money to cover window breakage, with the agreement that the student body could keep what was left over after payments for window repairs. The result was a dramatic reduction in window breakage.

Little systematic evaluation of preventive policies



that affect opportunities has been undertaken up to now. Nevertheless, even from the slender leads so far available, it does appear that these approaches contain the possibilities of actions that could make a worthwhile (although limited) impact on certain forms of adolescent problems. The leads are worth following further.

## CURRENT STRESSES AND STRENGTHS

The fourth potential area of intervention concerns current circumstances with respect to the level of stresses experienced, the coping methods possessed by children, and the protective or ameliorating factors that are available. It might be thought that this would be the major area for preventive action in that (at least in theory) it has the most direct connection with the development of disorders. However, surprisingly little is known about the role of stresses as precipitants of children's problems of any type,<sup>43</sup> and hence there is no ready point at which to obtain leverage for action. There is no doubt that further research is needed, both on the role of stresses and on the influence of protective factors. But regrettably, no immediate policy recommendations can be made with respect to preventive interventions in this field.

Of course, a considerable clinical literature has built up around the notion of crisis intervention as a means of preventing psychiatric problems. The idea has enormous appeal; in theory, it is brief, effective, strengthening, health-oriented, and capable of widespread community application. Unfortunately, apart from the already discussed actions in connection with hospital admissions there is very little evidence that it works. Indeed, the one study undertaken by Polak and colleagues<sup>44</sup> to evaluate crisis intervention following the sudden death of a family member (a situation in which there is good evidence that it is indeed a relevant stress) showed no benefits at all. Of course that does not mean that other forms of crisis intervention could not work, but it does imply that our level of knowledge in this area is not yet at a stage when it is possible to make recommendations on a community-wide application of this approach. The same applies to the availability of a supporting social network. There is good evidence for the importance of social supports in protecting people from emotional disturbance,<sup>3,43</sup> but little is known about the value of attempts to provide such supports for those individuals who lack them. The potential is there for prevention but it is yet to be realized.

## SUMMARY

It is all too evident that the area of primary prevention of psychosocial disorders of childhood is

indeed a minefield involving both the dangers of actually doing harm and the parallel danger of spending time and energies in well-meant activities that actually have no important effect. It is important that we do not oversell what can be achieved, because if we do, there is almost certain to be a backlash that will jeopardize the few effective modes of intervention that we do have at our disposal now.

The difficulty is not that there are no leads available. To the contrary, there are a multitude of leads. We know a good deal about the risk factors and the areas in which preventive intervention might be effective. What we know much less about is precisely how to intervene in order to bring about the results we desire. The implication is that we should move ahead to implement what we do know; to undertake systematic research, both to understand better the nature of children's stresses and their successful coping with them, and also to develop more effective methods of intervention; and finally to evaluate what we do. We should be optimistic for the future, but there is no easy road to success. Much needs to be done and much can be done, but there is no patent nostrum for the ills of society.

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# The Teaching of Crisis Counseling Skills to Pediatric Residents: A One-Year Study

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**ABSTRACT.** Pediatric residents should learn to manage family crises such as informing parents that their child has a potentially life-threatening illness. Unfortunately, few training programs prepare residents to counsel parents of a child with cancer. An experiential parent crisis counseling program has been developed at the Children's Hospital National Medical Center in Washington, DC; this program has demonstrated that pediatric residents, with limited instruction, can be taught to give bad news to parents using effective information-giving and interpersonal skills. *Pediatrics* 70:907-911, 1982; *interpersonal skills, residency training, crisis counseling.*

At no time is effective communication more critical than when the pediatrician is conveying the diagnosis of a potentially fatal illness in a child to the parents. The impact of such a traumatic event forces many parents to turn to their physicians for counsel and comfort. Many physicians, unfortunately, are unable to meet the parents' needs and concerns on a personal level or to help the parents adjust emotionally and cope successfully with the impact of the devastating news. Thus, an impasse often is reached in which the expectations of the parents exceed the service that the physician is able to render.

Problems in communication among doctors and patients or parents of a child with fatal illness are well recognized.<sup>1-4</sup> The Task Force on Pediatric Education found that more than half of young pediatricians rated their residencies as providing

insufficient experience with psychosocial and behavior problems.<sup>5</sup> Further, it was found by the Task Force that pediatricians need to acquire interpersonal skills and become competent in counseling in order to manage such family crises as life-threatening illnesses and death. The American Cancer Society (1979) has expressed concern over the lack of physician-patient communication skills. The Society recommends that an improvement be made in the way in which the cancer patient and his family are informed by the physician of a diagnosis of cancer; they further recommend that greater consideration be given to the psychosocial impact of the diagnosis.

A review of the literature reveals that the training and postgraduate education of physicians has focused mainly on the technical aspects of medicine. The rapid technologic and scientific advancements in medical care over the past 50 years have eliminated many serious and fatal diseases and have extensively improved the quality of health care. These achievements have also contributed to the increasing mechanization and dehumanization of medical care and the changing of the physician-patient relationship. However, the significance of the physician-patient relationship has been recognized only recently and consideration given to provide instruction in interpersonal and communication skills in the training and education of future physicians.<sup>6-8</sup> Most of this training has been in history taking and interpersonal skills and has occurred mainly in the preclinical years.<sup>6</sup> Further, most literature focuses on training physicians to obtain information; there has been little instruction in information-giving and counseling skills that physicians must employ with parents and patients to help them effectively cope with a potentially fatal illness.<sup>9</sup>

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The Physical, Emotional and Sexual Abuse and Neglect of Children

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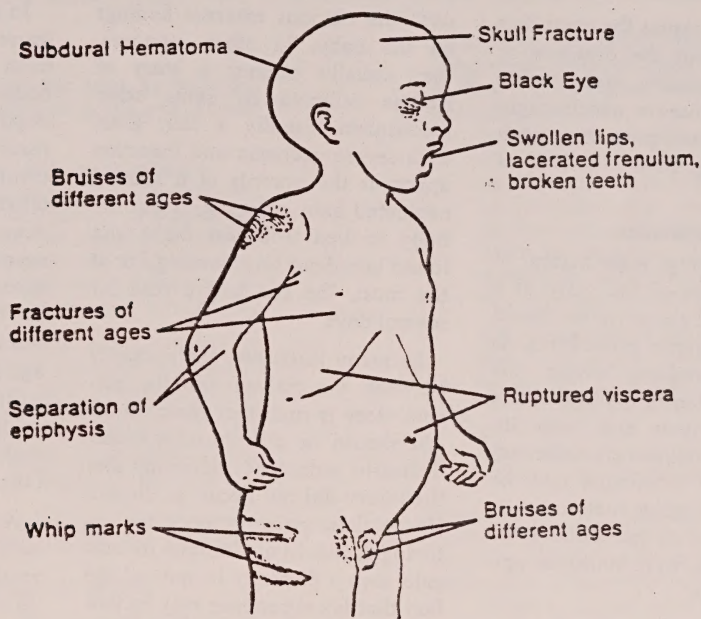
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Fig. 1

## INJURIES FREQUENTLY ENCOUNTERED IN MALTREATED CHILDREN



ing in hand after such a limited examination. But when later examined by a skilled defense counsel who may very well raise many questions concerning unexamined portions of the victim's body, the pathologist would be unable to answer these questions and this ultimately might force him to state that he could not determine, beyond a reasonable doubt, the cause of death to the exclusion of others because of the limited extent of his examination.

To avoid an allegation that some or all of the injuries are artefacts, the examination, as with all medicolegal autopsies, should be performed on only an unembalmed body. Again, it should be emphasized that the absence of any recognizable external trauma does not preclude the possibility that the baby died a violent death. The protection afforded by several layers of blankets or quilts often completely prevents external bruising beneath which there may be rupture of gastrointestinal tract, mesentery, and less frequently, liver, spleen, and occasionally, lung.

#### Painful Attention to Detail

If one were to summarize the procedure of a medicolegal examination in several words, this would be its essence: A good medicolegal examination should not include reference to a "large bruise over the left forehead" or "several small red bruises on the right chest" but rather should note and record in instances of suspected child abuse the *precise* location, the *precise* size, and the *precise* interrelationship of multiple discolorations as well as the obvious coloration, shape, and resemblance to any recognizable pattern. Only with this type of detail, documented if at all possible with a ruler in the photograph to enable even further reconstruction than described and included with the photograph a color comparison card such as may be obtained from a local paint store, can the pathologist be assured that ultimately he will be able to answer all of the queries which might subsequently be raised.

In the average medicolegal autopsy the external examination with its description and documentation

is a painful procedure. Modern recording devices are of great time-saving assistance by enabling the recording as observed and measured, thus avoiding the interim step of notetaking which often results in shortcuts. When injuries are poorly defined or obscured by post-mortem lividity, it is often of value to reexamine the child after autopsy and embalming.

#### Microscopic Examination

Microscopic examination may be invaluable in aging wounds on the exterior and interior of the body. Sections taken for this purpose should be individually identified as they are collected so that the microscopic picture may be compared with the gross appearance. Photomicrographs may be used in court if the pathologist is prepared to demonstrate the correlation between the gross and microscopic changes and point out the microscopic variation from normal and from wound to wound.

In childhood neglect cases a complete microscopic examination is imperative. Only by this means may



the pathologist assure the court that he has ruled out the presence of some pathologically recognizable constitutional disease which might result in death and presenting post-mortem findings similar to those of starvation.

### Radiologic Examination

Complete x-ray examination of all of the bones of the body in a suspected child abuse victim should precede any internal procedures. As described elsewhere within the series, these often reveal healed and healing soft tissue and bony injuries. If these injuries are sufficiently healed, the radiologist may be invaluable in aging such injuries. This may assist in establishing the fact that there were multiple episodes of trauma.

### Toxicology

Complete toxicologic examination should be conducted on all victims of suspected child abuse. Infrequently such examination reveals the presence of therapeutic agents which may have been administered in life for relief of pain. Likewise infrequently, illicit agents which may have been administered to provide sedation are identified. Rarely the coexistence of other noxious agents such as lead has been reported. Again, this procedure is often conducted largely to enable the pathologist to respond to the interrogating attorney that there is no possibility that poisoning played any significant role in causing death.

### Interpretation of Findings

The pathologist should be aware that after a fatal episode of child abuse, parents or other members of the family rarely readily admit to responsibility for the act and often will present themselves in the emergency room or to the pediatrician with the deceased baby and a story which is completely incongruous

with the obvious external findings on the baby. In other instances, they usually present a story of trauma inflicted by some other mechanism, usually a fall. Even with severe cachexia and inanition apparent the parents of a starved neglected baby may say, "I put the baby to bed well last night and found him dead this morning," or at the most, "he has had a cold for several days."

In many instances, the disparity between the trauma and the parents' story is such that the pathologist should be able to offer rather definitive judgment, indicating that the injury did not occur as alleged. Under these circumstances, the pathologist should not hesitate to indicate such a disparity in spite of the fact that his experience may be limited in the examination of child abuse deaths. Included in this group are those infants wherein the rupture of many abdominal and thoracic viscera indicates the mechanism of trauma to be pummeling and completely inconsistent with a fall.

### Subsequent Court Testimony

Mandatory reporting legislation, some form of which is now in effect in each of the fifty states, usually requires the pathologist to report findings suspicious of child abuse to some responsible local authority. Failure to do so may be a criminal offense and if injury occurs to another child in the family after the pathologist failed to report an earlier suspicious death, this could result in a malpractice complaint against him. Most of the reporting laws provide immunity from action for reporting incidents subsequently unsubstantiated, if the individuals were acting in good faith. Pathologists engaged in this practice should become familiar with their local laws and the parties to whom such cases must be reported.

In many other cases, when cause of death is subdural hematoma and external trauma to the body is minimal, it is completely impossible for the pathologist to reach a definitive conclusion concerning the mechanism of injury. In other instances, there may be evidence of severe punishment or repetitive injury to the child over a sustained period of time manifested by healing and healed traumatic wounds while the terminal episode again often a subdural hematoma with relatively minor trauma to the exterior of the head, is consistent with accidental injury as a result of a fall.

A conclusion concerning the mechanism of the injury should be reached only after consultation with all of the members of the team and then only as a result, not only of the observation of pathologic findings but also as a consequence of the investigative circumstances and conversations with members of the family, either perpetrators or witnesses. This should be clearly pointed out to the prosecuting attorney in order that he may properly present all the evidence from which the ultimate conclusion was reached before asking the pathologist for his opinion concerning the cause of death and the mechanism for this injury. ■



## EXAMINATION GUIDELINES FOR SUSPECTED CHILD ABUSE OR NEGLECT DEATH

### PROCEDURE

Examine exterior of body, clad, as received.  
*Look for any signs of cause and manner of death.*

Photograph overall body as received.  
*These photographs will aid in the documentation of the chain of evidence and serve to refresh the memory of the investigator and examiner. They may also reveal features not noted previously to support another hypothesis for the time.*

Search for and remove special items of evidence. (Individually package and label.)

*Trace evidence may provide clues to identify the assailant and/or to help in or rule out suspects. It may also be used to locate the scene of the crime or the location of the body after the crime.*

Undress body carefully over plastic bag and air dry clothing. Seal droppings with trace evidence.

*Same as immediately above.*

X-ray entire body. Review with radiologist.  
*The radiologist is invaluable in aging bony injuries and has a large repertoire of bone and soft tissue injury described within the radiology literature, associated with specific patterns of abuse.*

Examine exterior of body unclad, as received.

*Look for evidence of violence.*

Note and record degree, color, and distribution of livor mortis when initially examining body prior to autopsy.

*It is important to know the appearance of the body at the scene to determine if rigor and livor are appropriate for position of the body.*

Note whether or not anus is abnormal (dilated, patulous, torn, or abraded); photograph if significant.

*Anal appearance is vital to indicate recent as well as past rectal sexual intercourse and may give clues to the events leading to death. It should be described prior to swabbing.*

If case appears to be sex related, remove for microscopic and/or serologic examination as follows:

1. Swab of oral cavity—smear on two glass slides, fix (with spray) and then place in sealed, labeled screw-top tube.
2. Swab of rectal cavity—prepare as in #1 above.
3. Swab of vaginal cavity—prepare as in #1.

In addition, dab liquid material into center of four-inch square of clean, new paper towel or filter paper, outline with pencil, air dry, package, and label.

*Sperm can be identified microscopically with the aid of special stains. Acid phosphatase determinations can be made on the swabs. The tubes and dabs must be sealed and labeled to insure the chain of evidence. Dabs can be examined for acid phosphatase or used for serological techniques.*

*Saliva dabs can be analyzed for secretor groups. In case of spurious results, the remainder of the vaginal contents can be evaluated as above. The dabs are of particular value in the event liquid specimens putrefy inadvertently during transmission or storage.*

Describe clothing indicating general nature, defects due to violence of any type, their location, size (in centimeters), and approximate location (in inches from landmarks).

*Clothing defects may provide valuable clues about the cause and manner of death, as well as the events leading to death.*

Photograph external unusual features of body as received with body landmarks and identifying number in photograph.

*These photographs will aid in the documentation of the chain of evidence and serve to refresh the memory of the investigator and examiner. They may also reveal features not noted previously to support another hypothesis for the time.*

Remove control samples from body for trace evidence. Individually package as indicated. Seal and label:

- a. Hair from head
- b. Hair from axilla
- c. Hair from pubis
- d. Clippings of nails, left hand
- e. Clippings of nails, right hand.

*Samples of the victim's hair are necessary for comparison of any hairs found on the clothing or at the scene. If the victim attempted defense, fragments of skin, blood, or other trace evidence from the assailant might be under the finger-nails.*

Wash body down carefully, insuring that significant external findings are not removed.

*Subtle evidence of injury may be seen after the body is washed, especially if the skin is dirty. Vigorous cleansing*



should be avoided so as not to disturb delicate evidence of injury, i.e., gun-powder flakes, etc.

Examine exterior of body after cleansing. The removal of dirt, drainage, and debris may afford better visualization of external injury. The time delay associated with these procedures may allow the development of dependent lividity, thereby affording better delineation of anterior poorly delineated bruises.

Describe natural external features of body. This procedure is a normal part of the medicolegal autopsy and is vital for victim identification.

Describe in detail the identifying marks, scars, tattoos, etc., noting exact location, size, content, etc. Note whether tattoo is professional or non-professional in appearance.

*In unidentified remains, more detailed information concerning marks, scars, and tattoos may later assist in establishing identity from verbal descriptions and photographs.*

Describe unnatural external features of body (external evidence of injury):

1. Size, shape, color, location (either by body landmarks or above heel or buttocks)
2. Group collections of similar or contiguous injuries.
3. Note relationship of contiguous injuries to each other. Measure intervals on center. *This portion of the examination is paramount to a medicolegal autopsy and accurate, well performed, factual, yet concise descriptions are priceless. Precise location of wounds in certain instances is invaluable in reconstruction of body, assailant, and scene relationships.*

Photograph face of body from front with identification number in the photograph.

*This photograph will establish identity in court.*

Photograph unusual identifying features of body (tattoos, scars, etc.) with identifying number and landmarks in photograph.

*If the identification is questioned, documentation of unusual features will aid in positive identification.*

Photograph all external unusual features of body after cleansing with body landmarks, identifying number, ruler, and if necessary, color chart in photograph.

*These photographs document the descriptive report.*

Conduct dissection, stopping upon opening cavity to collect toxicology.

*Internal evidence of injury should not be obscured by careless organ removal.*

The organs should be viewed in situ and traumatic findings ascertained.

Collect appropriate samples for toxicology:

- a. Blood
- b. Urine
- c. Vitreous

*Blood should be collected from the heart and a large, more peripheral artery or vein and accordingly labeled. Urine should be collected in such a way as not to contaminate the sample with blood. Vitreous humor is technically more difficult to evaluate toxicologically, but usually represents a more reliable sample in massive internal trauma cases.*

Collect sample for serology:

- a. Blood

*Blood grouping of the victim's blood is vital information for comparison with blood stains found on the assailant or at the scene.*

Describe in situ internal evidence of injury, in detail, then therapy (if present).

*Descriptions must be thorough, accurate, and concise. Logically ordered descriptions are preferable.*

Photograph internal evidence of injury or therapy, in situ, if present.

*These photographs document the descriptive report.*

Describe internal evidence of injury, then therapy (if present) after dissection of organs.

*Descriptions must be thorough, accurate, and concise. Logically ordered descriptions are preferable.*

Photograph internal evidence of injury or therapy on organs, dissected, if present.

*These photographs document the descriptive report.*

Describe internal natural findings.

*Natural disease should not escape the eye of the forensic pathologist since natural disease may often play a role in traumatic death.*

Collect representative sections of unusual pathologic findings from appropriate organs and samples of all organs for histopathologic examination.

*This procedure is self-explanatory, is the standard procedure for all well conducted autopsies and is not unique to a forensic autopsy.*

Remove sections of various color and type of wounds, label and button individually, i.e., bruises, etc.

*Histological evaluation of wounds should not be disregarded. This infor-*

mation may provide important "event-time" relationships.

Retain appropriate gross organs as necessary for illustration to attending physician or as subsequent evidence in criminal or civil proceedings.

*Often the specimens themselves are the only acceptable evidence for review by consultants selected by opposing counsel or for appropriate demonstration to other experts in ancillary fields either in or out of court..*

Individually package significant portions of dried clothing, seal and label. Photograph significant findings with identifying number and ruler in photograph.

*Individual packaging will insure against cross-contamination with other articles of clothing and will aid in chain of evidence.*

Bag and seal all clothing including individually packaged.

*Bagging aids in preservation of the chain of evidence and helps avoid contamination of clothing.*

Complete description of findings and conclusions concerning cause and manner of death.

*The final report should be completed promptly after all pertinent examinations are finished. The rough drafts should be reviewed with the photographs. The smooth copy should be carefully reviewed to avoid typographical errors and errors of omission.*

Submit collected specimens to Forensic Physical Evidence Laboratory, obtain receipt.

*Such receipts are necessary in maintaining the proper chain of evidence.*

Reproduced from the *Handbook* for representatives of the New Mexico Medical Investigation Program.

#### RELATIONSHIP BETWEEN COLOR AND AGE OF CONTUSIONS

| Source             | Color                   | Age                    |
|--------------------|-------------------------|------------------------|
| Adelson            | Reddish blue or purple  | Initially              |
|                    | Bluish-brown            | 1-3 days               |
|                    | Yellow-green            | At least several days  |
|                    | Complete resolution     | Can require 1-3 wk     |
| Glaister & Rentoul | Violet                  | Initially              |
|                    | Dark blue               | About 3rd day          |
|                    | Greenish                | 5th-7th day            |
|                    | Yellowish               | 8th-10th day           |
| Camps              | Normal tint             | 13th-18th day          |
|                    | Red                     | Immediately            |
|                    | Dusky purple or black   | Turning fairly soon to |
|                    | Green                   | 5th-6th day            |
|                    | Yellow                  | 7th-10th day           |
| Polson & Gee       | Disappearing            | 14th-15th day          |
|                    | Red, dark red, or black | Not more than 1 day    |
|                    | Greenish tinge          | End of 1 wk            |
|                    | Yellowing               | End of 2 wk            |
| Spitz & Fisher     | Resolved completely     | End of 4 wk            |
|                    | Light bluish-red        | After a few hours      |
|                    | Dark purple             | Within 1 wk            |
|                    | Greenish-yellow         | End of 1 wk            |
|                    | Brown                   | Later than 1 wk        |
|                    | Disappearance           | 2-4 wk                 |



# PHYSICAL INDICATORS OF ABUSE

## A. Bruises and welts that may be indicators of physical abuse:

1. Bruises on any infant, especially facial bruises.
2. Bruises on the posterior side of a child's body.
3. Bruises in unusual patterns that might reflect the pattern of the instrument used, or human bite marks.
4. Clustered bruises indicating repeated contact with a hand or instrument.
5. Bruises in various stages of healing.

## B. Burns that may indicate abuse:

1. Immersion burns indicating dunking in a hot liquid ("stocking" burns on the arms or legs or "doughnut" shaped burns of the buttocks and genitalia).
2. Cigarette burns.
3. Rope burns that indicate confinement.
4. Dry burns indicating that a child has been forced to sit upon a hot surface or has had a hot implement applied to the skin.

## C. Lacerations and abrasions that may indicate abuse:

1. Lacerations of the lip, eye, or any portion of an infant's face (e.g., tears in the gum tissue which may have been caused by force feeding).
2. Any laceration or abrasion to external genitalia.

## D. Skeletal injuries that may indicate abuse:

1. Metaphyseal or corner fractures of long bones—a kind of splintering at the end of the bone (these are caused by twisting or pulling).
2. Epiphyseal separation—a separation of the growth center at the end of the bone from the rest of the shaft (caused by twisting or pulling).
3. Periosteal elevation—a detachment of the periosteum from the shaft of the bone with associated hemorrhaging between the periosteum and the shaft (also caused by twisting or pulling).
4. Spiral fractures—fractures that wrap or twist around the bone shaft (caused by twisting or pulling).

## E. Head injuries:

1. Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.
2. Subdural hematomas—hemorrhaging beneath the outer covering of the brain (due to shaking or hitting).
3. Retinal hemorrhages or detachments (due to shaking).
4. Jaw and nasal fractures.

## F. Internal injuries:

1. Duodenal or jejunal hematomas—blood clots of the duodenum and jejunum (small intestine) (due to hitting or kicking in the midline of the abdomen).
2. Rupture of the inferior vena cava—the vein feeding blood from the abdomen and lower extremities (due to kicking or hitting).
3. Peritonitis—inflammation of the lining of the abdominal cavity (due to a ruptured organ, including the vena cava).

## G. Injuries considered to be indicators of abuse should be considered in light of:

1. Inconsistent medical history.
2. The developmental abilities of a child to injure itself.
3. Other possible indicators of abuse.

## H. Questions to ask in identifying indicators of abuse:

1. Are bruises bilateral or are they found on only one surface (plane) of the body?
2. Are bruises extensive—do they cover a large area of the body?
3. Are there bruises of different ages—did various injuries occur at different times?
4. Are there patterns caused by a particular instrument (e.g., a bolt buckle, a wire, a straight edge, coat hanger, etc.)?
5. Are injuries inconsistent with the explanation offered?
6. Are injuries inconsistent with the child's age?
7. Are the patterns of the injuries consistent with abuse (e.g., the shattered egg-shell pattern of skull fractures commonly found in children who have been thrown against a wall)?
8. Are the patterns of the burns consistent with forced immersion in a hot liquid (e.g., is there a distinct boundary line where the burn stops—a "stocking burn," for example, or a "doughnut" pattern caused by forcibly holding a child's buttocks down in a tub of hot liquid)?
9. Are the patterns consistent with a spattering by hot liquids?
10. Are the patterns of the burns consistent with the explanation offered?
11. Are there distinct patterns caused by a particular kind of implement (e.g., an electric iron, the grate of an electric heater, etc.) or instrument (e.g., circular cigarette burns, etc.)?

## DYNAMICS OF ABUSE\*

### I. PARENT

- A. Often abused as child
- B. Expected to meet high demands of parents
- C. Unable to depend on parents for love and nurturing
- D. Cannot provide emotionally for themselves as adults
- E. Expects child to fill void
- F. Expects rejection—low self-esteem
- G. Isolated
- H. Marries emotionally non-supporting spouse, spouse who actively supports the abuse

### B. Singled out as "different"

1. Unwanted pregnancy/wanted pregnancy with high expectations
2. Reminder of parental indiscretion
3. Too active or too passive
4. Wrong sex
5. Birth defect
6. Reminder of disliked characteristic of parent or other
- C. Poor bonding process at birth
- D. Role reversal
- E. Parents unable to tolerate child at certain stages of development

### II. CHILD

- A. Embodies rejected role of parents as a child

### III. CRISIS

- A. Can be major or minor
- B. Often the culmination of several crises

\* NOTE: These characteristics are based on a study of many cases of abuse. It should not be considered that every abuser fits every one of these characteristics.



Children who are abused physically or emotionally display certain types of behavior. Many of these are common to all children at one time or another, but when they are present in sufficient number and strength to characterize a child's overall manner, they may indicate abuse. More than simple reactions to abuse itself, these behaviors reflect the child's response to the dynamics of the family and especially to disturbed parent-child interactions. They are mechanisms for survival in a world where children are either unable to fulfill certain basic needs at all, or can fulfill them only by denying, suppressing or exaggerating important parts of themselves. Frequently learned in infancy, these behaviors become a child's "mode of operation" used to cope with the world at large. The behaviors which characterize abused children fall into four categories:

1. Overly compliant, passive, un-demanding behaviors aimed at maintaining a low profile, avoiding any possible confrontation with a parent which could lead to abuse. The child has adapted to the abusive situation by trying to avoid any behavior which the abusive parent notices at all.
2. Extremely aggressive, demanding and rapacious behaviors, sometimes hyperactive, caused by the child's repeated frustrations at getting basic needs met. In effect, the child has also adapted, by seeking to provoke the needed attention with whatever behavior it takes to get that attention.
3. Role-reversal behavior or extremely dependent behavior in response to parental emotional and even physical needs. Abusive parents have been unable to satisfy certain of their own needs appropriately and so turn to their children for fulfillment. Their failure can produce two opposite sets of behavior in their children. If a parent needs parental attention, the child may be expected to assume this task, and become inappropriately adult and responsible. Other parents, with a need to keep their child dependent, will produce clinging, baby-

ish behavior in the child long after a child in a healthy family would have become more self-reliant.

4. Lags in development. Children who are forced to siphon off energy normally channeled towards growth into protecting themselves from abusive parents may fall behind the norm for their age in toilet training, motor skills, socialization and language development. Developmental lags may also be the result of central nervous system damage caused by physical abuse, medical or nutritional neglect or inadequate stimulation. There may, of course, be organic or congenital causes for such lags in development.

Some abused children live in an uncertain environment where requirements for behavior are inconsistent and unclear. In some families, abuse is frequent and severe enough to be emotionally and physically harmful but insufficient to threaten physical survival. Frequently, discipline is meted out arbitrarily in response to the parent's needs and feelings at the moment, rather than to punish a child for transgressing clear limits. Children may receive some love, affection and security from their parents but are also often frustrated in attempts to fulfill their needs. This inconsistency creates anger and frustration in the child which is frequently expressed indirectly with the parents, or by explosions with others outside the home.

Other abused children learned to do what the abusive parent wants or expects. At the other end of the spectrum from overly aggressive children, some adapt quickly to others' expectations. Unlike children who act out their frustration and rage, these children may have learned not to expect anything in the way of love or support. Their best efforts are directed at avoiding conflict which, in the context of the abusive family, can be triggered by expressing almost any kind of personal need, curiosity, anger or playfulness.

## IDENTIFYING NEGLECT

### 1. Abandonment:

A child who is left totally alone and is found either wandering in the streets, left with an adult with parents failing to return, left at home with parents failing to return or left outdoors for someone to find and care for.

Factors to consider:

- a. Child's age.
- b. Parents' whereabouts.
- c. Parents' intentions.
- d. Length of time left alone.

### 2. Lack of Supervision:

An unsupervised child is one who is left alone for long periods of time or left alone when engaged in dangerous activities; a child or children left in the care of other children too young to protect them.

Factors to consider: There is no cut-and-dried age at which children can be left unsupervised. Must consider:

- a. Age of child.
- b. Length of time alone.
- c. Responsibilities assigned to child.
- d. Maturity of child.
- e. Will child hurt self or others?

### 3. Lack of adequate clothing and good hygiene:

(1) Child dressed inadequately for the weather or suffers persistent illnesses like pneumonia, frostbite or sunburn that are associated with excessive exposure, (2) suffers with severe diaper rash or other persistent skin disorders resulting from improper hygiene, or (3) is chronically dirty or un-bathed.

Factors to consider:

- a. Is the child's manner of dress actually harming the child? Would the parents immediately respond to help? Is there a cultural difference in standards of dress?
- b. Could a "perfume" in a disposable diaper be causing diaper rash? Is a detergent causing skin irritation? Have the parents been advised of a possible cause-effect relationship?
- c. How much dirt is too much dirt? Is the child suffering physical or emotional harm such as rejection from peer group because of odor?

### 4. Lack of medical or dental care:

A child whose needs for medical dental care are unmet is a child who (1) has teeth that are rotting, (2) will suffer physical pain or discomfort which could be relieved by medical attention, (3) is not immunized against disabling illnesses.

Factors to consider:

- a. Diet.
- b. Religious practices and beliefs.
- c. Community requirements and standards.

### 5. Lack of adequate education:

When a child is chronically absent from school or skips classes.

Factors to consider: Who in the community has the primary responsibility for truancy? Type of intervention is often dependent on:

- a. Is the child staying home to care for younger siblings or parents?
- b. Is the child frequently ill?
- c. Are the parents aware of child not attending school?

### 6. Lack of adequate nutrition is what the child:

- a. Lacks sufficient quantity or quality food.
- b. Constantly complains of hunger and/or rummages or begs for food.
- c. Suffers from severe malnutrition or developmental lags.

Factors to consider:

- a. Cultural differences in eating habits.
- b. Poverty or possible physical (medical) etiology.

### 7. Lack of adequate shelter:

When the child is exposed to (1) structurally unsafe housing or exposed wiring, (2) inadequate or unsafe heating, (3) unsanitary housing conditions, (4) poor lighting, (5) poor ventilation.

Factors to consider:

- a. Unsafe wiring is deadly—determine responsibility and make sure changes are made.
- b. Consider climate vs. need—is heat properly vented?
- c. Determine objective standards of level of cleanliness which could create harm to the child.



## RADIOLOGIC MANIFESTATIONS OF THE BATTERED CHILD SYNDROME

In cases in which the battered child syndrome is suspected, the presence of radiographic changes in the skeleton can support the diagnosis; the absence of radiologic changes does not necessarily exclude it. Lesions of the metaphyses are common and quite typical. This is probably due to the fact that most injuries occur as a result of vigorous handling (as in shaking the child) and not from direct blows. Therefore, in children under one year of age, you would expect separation to take place at the cartilage-shaft junction which is a weak point.

When abuse is suspected in a child under 5 years of age, a radiologic bone survey consisting of x-rays of the skull, thorax, pelvis, spine, and long bones should be made. These films are of great diagnostic value, since the clinical findings of fracture often disappear in 6 or 7 days even without orthopedic care. In children over the age of 5 years, roentgenograms need to be obtained only if there is bone tenderness or a limited range of motion on physical examination. If x-rays of a tender site are initially negative, they should be repeated in 2 weeks to detect any calcification of subperiosteal bleeding or nondisplaced epiphyseal separations that may have occurred. Babies with nutritional deprivation also need radiologic surveys; approximately 10 per cent of them have associated skeletal injuries.

Some abused children have overt fractures. The most diagnostic radiologic findings are multiple injuries to bones at different stages of healing; such findings imply repeated assaults. The classic early finding, however, is a chip fracture or corner fracture: a corner of the metaphysis is torn off, with the periosteum, during wrenching injuries to the long bone. From 10 to 14 days later, calcification of subperiosteal bleeding will become visible at the periphery. By 4 to 6 weeks after injury, the subperiosteal calcification will be solid and start to smooth out and remodel.

Unusual fractures of the ribs, lateral clavicle, scapula, or sternum should arouse suspicion of nonaccidental trauma. Rare bone disorders, such as osteogenesis imperfecta, infantile cortical hyperostosis, scurvy, syphilis, ordinarily be easily differentiated.

### SUMMARY

#### HALLMARKS OF THE CLASSIC BATTERED CHILD SYNDROME

METAPHYSEAL AVULSION FRACTURES. Even one is suspicious.  
SUBPERIOSTEAL HEMORRHAGE. (Hemorrhagic involucrum.)  
MINOR PERIOSTEAL REACTION. (Particularly in a reportedly acute injury.)  
SPIRAL OR TRANSVERSE FRACTURES. (With inadequate explanation as to the severity of the trauma or the mode of injury.)  
UNUSUAL FRACTURES. (Lateral clavicle, scapula, sternum, ribs, vertebral compression with or without disc space narrowing.)  
UNUSUAL OR UNEXPLAINED SOFT TISSUE INJURIES. (Duodenal, jejunal hematoma, pancreatic pseudocyst, renal contusion, vascular avulsion.)

- \*MULTIPLE FRACTURES.
- \*VARYING STAGES OF HEALING.
- \*UNDERLYING SKELETAL ARCHITECTURE WHICH IS NORMAL.
- \*SUBDURAL HEMATOMAS/HYGROMAS BY C.T.

DIFFERENTIAL DIAGNOSIS OF THE  
MANIFESTATIONS OF THE BATTERED CHILD SYNDROME

Radiographic Similarities

Helpful Distinguishing Features

|                                  |                                                                                             |                                                                                                                                                                                                                                                                                      |
|----------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| curvy                            | Massive subperiosteal hemorrhage (clinically, hemorrhages in gums, skin, mucous membranes). | Generalized osteoporosis; dense "Wimberger's" line around the epiphysis; lucent submetaphyseal zones; dense metaphyseal lines with healing phase. (Clinically, rare; usually diagnostic history; diagnostic serum changes; dramatic clinical improvement after 24 hours of therapy). |
| Osteogenesis imperfecta          | Multiple fractures, exuberant calcified callus formation, limb deformity.                   | Generalized, marked osteoporosis; multiple sutural bones in the skull; platyspondyly in Congenita form (clinically, well-defined clinical changes in eyes, skin, appropriate family history).                                                                                        |
| Rickets                          | Irregular metaphyses and metaphyseal avulsions.                                             | Generalized disease with symmetrical involvement of many metaphyses and radiographic involvement of the entire length of the metaphysis. Generalized osteoporosis.                                                                                                                   |
| Caffey's Disease                 | Multiple sites of periosteal reaction, soft tissue swelling.                                | Absence of fractures; 95% of cases involve the mandible. (Clinically, fever, nonhemorrhagic soft tissue swellings, leukocytosis, increased sedimentation rate, elevated alkaline phosphatase).                                                                                       |
| Syphilis                         | Periosteal reactions; metaphyseal lesions.                                                  | Metaphyseal lesions are erosive; no fractures. (Clinically, characteristic physical findings, positive serology).                                                                                                                                                                    |
| Neurogenic sensory deficits      | Metaphyseal fractures, periosteal reaction, multiple fractures.                             | Degenerative and proliferative changes around joint; osteoporosis; x-ray changes may follow institution of physical therapy on paralyzed limb.                                                                                                                                       |
| Congenital insensitivity to pain | Multiple fractures, with varying stages of healing; deformity.                              | Destruction of terminal phalanges, changes of osteomyelitis; particularly in mandible, fingers, toes; aseptic necrosis in the juxta-articular regions of the weight-bearing bones in older patients.                                                                                 |



Menke's  
Syndrome  
(Kinky Hair  
Syndrome)

Metaphyseal avulsion;  
diaphyseal periosteal re-  
action and thickening;  
subdural effusion.

(Clinically, rare; sex-linked  
recessive disease; characteristic  
hair changes; widespread abnormal  
arterial tortuosity angiographi-  
cally and pathologically; copper  
deficiency.)

Physiologic  
Periostitis  
of Infancy

Periosteal elevation of the  
long bones in infants.

Mild, smooth, single layer of  
periosteal elevation; symmetrical;  
limited to the diaphysis; no meta-  
physeal avulsions; (clinically,  
inapparent, often an incidental  
finding.)

Generally Unusual Fractures in the Pediatric Age Group:

Lateral Aspect of Clavicle (Except as Neonate)

Transverse Sternal Fractures

Scapular Fracture

- (1) Transverse scapular fracture
- (2) Fragmentation of the acromion

Spinal Injury

- (1) Anterior notching of the vertebral body
- (2) Compression of the vertebral body
- (3) Disc space narrowing with sclerotic, narrow vertebral  
bodies above and below the abnormal discs

Rib Fractures

Statistical Analysis of Site of Fractures.\*

|         |   |     |
|---------|---|-----|
| Ribs    | - | 72  |
| Humerus | - | 42  |
| Femur   | - | 32  |
| Tibia   | - | 31  |
| Skull   | - | 25  |
| Hand    | - | 15  |
| Ulna    | - | 12  |
| Radius  | - | 11  |
| Spine   | - | 10  |
| Others  | - | 15  |
| TOTAL   |   | 264 |

\*  
From Akbarnia, et.al.

Analysis of Types of Fractures Seen.\*

|                            |   |          |
|----------------------------|---|----------|
| Positive X-Ray Findings    | - | 63 (66%) |
| Fractures                  | - | 52 (55%) |
| Transverse, Spiral         |   |          |
| Fractures                  | - | 30 (31%) |
| Epiphyseal, Metaphyseal    |   |          |
| Fractures                  | - | 14 (15%) |
| Calvarial Changes (Plus    |   |          |
| or Minus Fx)               | - | 40 (42%) |
| Skull Fracture             | - | 21 (22%) |
| Spread Sutures Only        | - | 17 (18%) |
| Soft Tissue Findings       | - | 9 (10%)  |
| Soft Tissue Findings Alone | - | 4 (5%)   |
| Multiple Fractures         | - | 22 (23%) |
| TOTAL                      |   | 272      |

\*  
From Kogutt, M. S., et.al.



## POSTMORTEM VITREOUS CHEMISTRY

1. Dehydration Pattern -  
Elevated vitreous sodium (over 155 mEq/L)  
Elevated vitreous chloride (over 135 mEq/L)
2. Uremia pattern -  
have marked vitreous and serum urea and creatinine WITHOUT a significant rise in sodium and chloride values.
3. Low Salt pattern -  
characteristically has a:  
Low vitreous sodium (less than 130 mEq/L)  
Low vitreous chloride (less than 105 mEq/L)  
relatively low vitreous potassium (less than 15 mEq/L)  
(Concomitant slight rise in serum bilirubin and low BUN - below 5 mg/dL).  
This pattern common in chronic alcoholic
4. Decomposition pattern -  
like low salt pattern - with low vitreous sodium and chloride but with decomposition there will be a high vitreous potassium (over 20 mEq/L)

## CHILD SEXUAL ABUSE: Incest, Assault, and Sexual Exploitation

### *Definitions*

The sexual abuse of children has been called the "last remaining component of the maltreatment syndrome in children yet to be faced head on."<sup>2</sup> It encompasses a wide range of behavior from fondling and exhibitionism to forcible rape and commercial exploitation for purposes of prostitution or the production of pornographic materials. It takes many forms and involves varying degrees of violence and emotional traumatization. Sexual abuse has been defined in a variety of ways. Some of the ambiguity in terms can be attributed to the differences in legal definitions of sexual abuse which vary considerably from state to state. But the basic cause of this ambiguity is the multitude of variations in sexual acts or behaviors, in perpetrators, and in the degree of harm or effect on children.

The Federal Child Abuse Prevention and Treatment Act of 1974, as amended, defines child abuse, including sexual abuse or exploitation, in terms of injury or maltreatment of a child "...by a person who is responsible for the child's welfare..." As used in Subsection 5(3) of the amended Act, the term "sexual abuse" includes "the obscene or pornographic photographing, filming or depiction of children for commercial purposes, or the rape, molestation, incest, prostitution or other such forms of sexual exploitation of children under circumstances which indicate that the child's health or welfare is harmed or threatened thereby..."<sup>3</sup>

Legal definitions of child sexual abuse sometimes vary by factors in addition to what was actually done to a child: the victim's age and relationship to the perpetrator are also taken into account in many states. Furthermore, because most child abuse reporting laws address themselves to maltreatment by parents or persons legally responsible for a child's welfare, an act of sexual abuse committed by a person outside the family may be defined and handled quite differently from the same act committed by someone legally responsible for the child.<sup>4</sup>

As with other forms of child abuse, there is generally agreement concerning the most extreme cases, but the operational definition of what specific behaviors constitute sexual abuse of children remains largely a matter of jurisdictional and individual interpretation. Many of the terms in the literature that differentiate types of child sexual abuse are used interchangeably by professionals and the public. As more has become known about this problem, even such unintentional behaviors as obscene language or accidental sexual stimulus have been discussed as possibly constituting sexual abuse.

In order to encompass all forms of child sexual abuse and exploitation within its mandate, the National Center on Child Abuse and Neglect has adopted the following tentative definition of child sexual abuse:

contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of that adult or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child.

### *Scope of the Problem*

How frequently does child sexual abuse occur? The true extent of the problem is unknown, since there are presently no national statistics on the actual incidence of child sexual abuse. Available statistics reflect only those cases that are officially reported to appropriate authorities and represent only a fraction of the cases that actually occur. Some researchers believe that sexual abuse is more widespread than the physical abuse of children, which is currently estimated to affect over 200,000 children a year in the U.S. A study by Weinberg, published in 1955, estimated the average yearly rate of incest to be 1.9 cases per million people.<sup>5</sup> More recent estimates have been considerably higher: in 1969, Vincent DeFrancis, M.D., and the American Humane Association estimated



a yearly incidence of about 40 per million.<sup>6</sup> The number of cases seen at the Santa Clara County (California) Child Sexual Abuse Treatment Program suggests that the true incidence could be as high as 800 to 1,000 per million. The National Center on Child Abuse and Neglect currently estimates that the annual incidence of sexual abuse of children is over 100,000 cases per year.

For many researchers this incidence estimate is conservative. Authorities have offered a range of possible incidence figures, such as Schultz's estimate of 200,000-500,000 cases a year.<sup>7</sup> In a study based on retrospective interviews with females, Gagnon estimated that as many as 500,000 girls under 14 years of age are victims of sexual offense each year.<sup>8</sup> Another estimate within range of these assessments is Sarafino's projection of 336,000 actual sex offenses against boys and girls each year.<sup>9</sup> In a recent survey of predominantly white, middle class college students, nearly one in five girls and one in 11 boys said they had a sexual experience in childhood with a much older person.<sup>10</sup>

The variation among these estimates is primarily attributable to the methods employed in their computation. Such factors as the definition of sexual abuse utilized, the age range covered, and whether or not boys were included in the estimate are influential. Gagnon's estimate of 500,000 cases per year is based on interview data from the Kinsey research on females which involved a sample of 1,200 adult women, of whom 28 percent indicated at least one sexual incident before 13 years of age.<sup>11</sup> Many of the incidents were minor, such as exhibition, and this partially accounts for the higher incidence he records. As in many of the retrospective studies on sexual abuse, the samples used in his research were skewed toward middle- and upper-class college educated white women. Any resultant bias in a sample so small would be magnified to a great extent when projected to the entire population. Sarafino drew his sample from actual police records in four locations, and by combining all reported sex offenses (including adult rape) into one category, alleviated inaccuracies resulting from deliberate misclassification by authorities (conviction is easier to obtain on a charge of indecent liberties than on more serious charges). He thereby attempted to compensate for the lack of standardization among states and communities regarding definitions of sex offenses. After establishing a ratio of unreported to reported sex crimes at three-and-one-half to one,

Sarafino arrived at a national incidence figure of 336,200 sexual offenses against boys and girls each year. The potential bias in this study comes from the assumption that the ratio of unreported to reported sex crimes was the same for each type of crime and each sex, as well as the assumption that the four locations making up the sample were representative of the country as a whole.<sup>12</sup> Further variations in studies arise from different operational definitions of the sexual abuse incident. DeFrancis considered only cases involving "abusive, physical contact," while Gagnon included any form of sexual incident, even exposure of the genitals.<sup>13</sup>

Most estimates of the incidence of child sexual abuse do not include children who are the victims of pornographic exploitation and child prostitution. These are forms of sexual abuse which have only recently become the subjects of investigation and research. While the number of children involved in the production of pornographic materials is not known, juvenile delinquency experts have estimated that there may be 300,000 male prostitutes under 16 years of age. Other authorities have estimated that the number of girls involved in prostitution is roughly the same.<sup>14</sup> Some of the children are runaways, others are from broken families where the parents or guardians are addicted to drugs or alcohol. In the worst of these cases the parent introduces the child to pornography or prostitution to support the addiction.<sup>15</sup> The commercial success of pornography, which has been estimated to be a multimillion dollar business,<sup>16</sup> would appear to ensure a continuing threat of sexual exploitation to children.

There are a number of reasons to suppose that reported cases of sexual abuse represent only the "tip of the iceberg." One of these is the reluctance of many parents and family members to report such incidents to the authorities. Fear of social censure, shame, an unwillingness to subject the child and/or the parents to embarrassing questioning, and the fact that in most cases no physical harm has been done all contribute to this reluctance. Moreover, children often do not report incidents of sexual abuse to their parents. They may be afraid that their parents will blame them; they may be afraid of reprisal by the perpetrator (who may be one of their parents); or they may feel guilty over any physical pleasure they may have had from the sexual contact. In a retrospective study of 1,800 college students, almost a third of the respondents of both sexes reported



that they had been subjected to some form of sexual abuse as children.<sup>17</sup> Only half of the females who had such an experience reported it to their parents; only one tenth of the males did so. It is clear that the actual number of incidents of sexual abuse of children is considerably greater than the number of incidents that come to the attention of the authorities.

### *Dynamics of Sexual Abuse*

The familiar images of "perverts," "molesters," and "dirty old men" are not accurate portraits of the majority of persons responsible for the sexual abuse of children.<sup>18</sup> Studies of sexually abused children show that a large proportion of such cases involve parents or other figures familiar to the child. Of 9,000 cases of sex crimes against children reviewed by the American Humane Association in 1968, 75 percent were perpetrated by members of the victim's household, relatives, neighbors, or acquaintances of the victim.<sup>19</sup> Half the offenders in a series of 42 cases involving sexual trauma of children and adolescents were found to be family members.<sup>20</sup> Other studies show that parents, parent substitutes, or relatives are the perpetrators in 30 or 80 percent of all cases.<sup>21</sup> Still others estimate that between 20 and 30 percent of all child abuse cases are perpetrated by nonfamily members. It has also been reported that only 3 to 10 percent of the offenders were total strangers.<sup>22</sup>

The circumstances, dynamics, and effects of child sexual abuse differ depending on whether the perpetrator is a stranger or someone with whom the child is closely acquainted. The behavior of the perpetrator is more likely to be an expression of a sexual preference for children in cases of assault by a stranger than is that found in incest cases, where an individual's normal sexual preference for adults may have become thwarted, disoriented, or inappropriately directed toward a child. While aggressive sexual offenses, such as rape and sadism, do occur within the family, they are the exception rather than the rule. The majority of cases do not involve penetration, contraction of venereal disease, or infliction of serious injury. Exhibitionism and fondling by strangers, often compulsive and habitual forms of behavior, are rarely violent and may have little impact on their victims, depending upon how the situation is subsequently handled.<sup>23</sup>

Sexual abuse by strangers is usually a single episode, occurs most frequently in the warm weather months, and usually occurs in a public place. In contrast, sexual abuse by family members or acquaintances is more likely to occur in the home of the victim or the perpetrator, and may occur repeatedly over a period of time.<sup>24</sup>

While there are cases of sexual abuse by adult women, the overwhelming majority of perpetrators are men. Girls are reported as abused at a much higher rate than boys (the estimated ratio ranges from twice to ten times as often), and although victims have been found to be as young as four months old, the average age appears to be between 11 and 14 years old.<sup>25</sup> Recent studies indicate, however, that these estimates may be more a reflection of the cases that are reported, rather than an actual indication of the age and sex of the majority of victims. For example, the 1978-79 statistics from the Child Protection Center of Children's Hospital National Medical Center, which treats all forms of child sexual abuse, reveal that the average age of victims is 7 years, and that 25 percent of them are males.<sup>26</sup> Similarly, in a recent report by the Hennepin County (Minnesota) District Attorney's Office which identified previously undisclosed cases of child sexual abuse, as many boys as girls in the lower elementary school age levels identified themselves as having experienced some form of sexual abuse. These and similar data from other parts of the country increasingly point to the conclusion that, in younger children, as many boys as girls are vulnerable to sexual abuse and exploitation but that boys may be even more reluctant to report such incidents to adults.<sup>27</sup> In addition, preliminary findings from the evaluation of NCCAN's four large intrafamily sexual abuse demonstration treatment projects indicate that 21 percent of the children being treated for sexual abuse are under the age of 12, with a least one project showing 51 percent of its child client population as 11 years old or younger, and one-third of its population under the age of six.<sup>28</sup>

It has been suggested that sexual abuse by adult women is reported infrequently because the social censure surrounding that behavior discourages its disclosure. Yet, the Kinsey report and others suggest a major discrepancy between the childhood sexual experiences of boys and girls, and cast considerable doubt on this explanation. A different approach has been taken by feminist authors who find it significant that



this disparity is not discussed. Why, they ask, does father-daughter incest occur so much more frequently than mother-son incest? Why, in the face of documented evidence of this fact, has there been little or no previous attempt to explain this? Why is there so much blame placed on the victim when incest is finally acknowledged? The answer, from the feminist perspective, is that within a patriarchal society, mother-son incest is an affront to the father's prerogatives, and this gives rise to the asymmetrical nature of the incest taboo. Some authors have concluded that although father-daughter incest is forbidden, it is not as abhorrent; and since the prohibition carries less weight, it is more frequently violated, or at least more frequently reported.<sup>29</sup>

There is evidence that most perpetrators of sexual abuse are heterosexual in their adult sexual orientation, even though they may abuse male children. Sarafino states that in 92 percent of the reported child sexual abuse cases the perpetrators are heterosexual.<sup>30</sup> No perpetrators with a homosexual orientation were found in a study of 175 males convicted of sexual assault against children. The study suggests that the adult heterosexual male constitutes a greater risk to the underage male or female child than does the adult homosexual male (who is much less likely to have children around the house).<sup>31</sup>

In cases where the perpetrator is a family friend or member, the use of physical force is rarely necessary to engage a child in sexual activity because of the child's trusting, dependent relationship with the perpetrator. The child's cooperation is often facilitated by the adult's position of dominance, an offer of material goods, a threat of physical violence, or a misrepresentation of moral standards. In complying with the adult's wishes, a child may also be attempting to fulfill needs that normally are met in other ways. For example, a child may cooperate out of a need for love, affection, attention, or from a sense of loyalty to the adult. Conversely, a need to defy a parental figure, express anger about a chaotic home life, or act out sexual conflicts may make a child vulnerable to sexual abuse and exploitation.

Other reports of child sexual abuse in the family suggest an elevated incidence of violence. In a study of 44 cases of attempted and completed child sexual assault by a family member, 39 percent of the offenders were categorized as committing a sex-pressure assault while 61 percent

were categorized as committing a sex-force assault. In the sex-pressure assault the offender is an authority figure to the victim and pressures the child, who may not know that sexual activity is part of the offer. Sexual approaches by a family member are often presented to the child as instructional. Sex-force assaults, on the other hand, involve the threat of harm or physical force, rather than engaging the child in an emotional way. Intimidation and exploitation are used to gain power. In some cases this type of assault may be sadistic, where the child may be beaten, choked, or tortured, and where the intent of the perpetrator is to hurt, punish, or destroy the victim.<sup>32</sup>

Incest, or sexual abuse in which the perpetrator and the child victim are members of the same family, is a highly emotionally charged and socially intolerable form of sexual abuse. For most people, incest is the most threatening and difficult form of child sexual abuse to understand and accept. It is also the most difficult form of sexual abuse to detect because incest, by its very nature, tends to remain a family secret. Generalizations about its etiology, effects, and treatment are necessarily tentative because most published research on the subject is based on small numbers of cases.

Father-daughter incest and incest involving a father-figure are the most commonly reported types; mother-son, mother-daughter, and father-son incest are believed to be more rare. Sexual activities between age peers (brothers and sisters; cousins) are probably the most prevalent though least reported type of incest, and are not generally considered harmful to the participants (unless, as stated previously, they involve the use of power, force or coercion).

In what type of family does incest occur, and under what conditions? One researcher identified five family conditions which could lead to father-daughter incest: 1) the emergence of the daughter as the central female figure of the household, in some respects taking over the role of the mother; 2) the relative sexual incompatibility of the parents; 3) the unwillingness of the father to seek a partner outside the nuclear family; 4) pervasive fears of abandonment and family disintegration, such that the family is desperately seeking an alternative to disintegration; and 5) unconscious sanction by the mother, who condones or fosters the assumption by the daughter of a sexual role



with the father.<sup>33</sup> Another researcher differentiates three types of incestuous fathers: fathers in whom the incest is part of a pattern of "indiscriminate promiscuity"; fathers with an intense craving for young children (pedophilia); and fathers who, in the absence of a satisfying relationship with their wives, choose a daughter as a sexual partner because they do not wish to cultivate sexual contacts outside their own families.<sup>34</sup> Descriptions of the father have ranged from passive, ineffective, or introverted, to strong, authoritarian, or dominating.<sup>35</sup> Other views stress the dual role of a father who uses his authoritarian position to control the daughter's behavior, secure her developing sexuality for himself, or protect her from rival boyfriends, while at the same time playing the awkward adolescent lover.<sup>36</sup>

Social isolation is often a characteristic of incestuous families, as is the case with child abuse generally, and the existence of incestuous relationships tends to isolate the family even further. A number of researchers have noted the association of alcohol intoxication with many incestuous incidents.<sup>37</sup> It has also been observed that a disproportionate number of perpetrators in court cases are from the lower socioeconomic classes,<sup>38</sup> but this may reflect the fact that middle and upper income perpetrators may be in a better position to avoid contact with the courts.

Although incest can and does exist without the knowledge of the mother or other family members, it sometimes involves the collusion of all members of the family. This collusion may take the form of unconscious denial, or it may take more active forms. Some authorities view the "collusive" aspects of incestuous families as a predictably self-protecting stance in view of the danger of a long prison sentence, loss of financial support, loss of family reputation in the community, and the creation of a recriminating and angry atmosphere within the home.<sup>39</sup>

While studies of incest traditionally have focused on the individual pathology of the participants, more recent studies have centered on the non-overt participant. Incest in these later studies is seen as involving an interpersonal triangle in which the mother has relinquished her role to the oldest daughter, or in some cases, reversed the mother-daughter role, assuming with her daughter the role she wished to have played with her own rejecting mother.<sup>40</sup> The high incidence of incest among oldest daughters, as well as the generational

recurrence of the problem, would appear to reflect this dynamic. Besides having problems in her affective relationship with her child, the mother's behavior toward her daughter often resembles a sibling relationship. The child may be described by the collusive mother in terms of her unmet needs.<sup>41</sup> In a study of older women victimized by incest as children, all of the women identified the inadequate relationship with their mother as the most long lasting and destructive element of the experience. The residual anger directed at the mother was found to be the least responsive symptom to treatment.<sup>42</sup>

### *Effects on Children and Families*

It is difficult to generalize about the effects of sexual abuse on children. Aside from the fact that there has been little research on the effects of sexual abuse, children react differently to different situations depending on a number of variables that may be operating at the time of the occurrence. In an absolute sense, the question of what effects incest has had on the child is unanswerable since there is usually no way that the effects of the sexual events can be separated from the family pathology in which they occurred.<sup>43</sup>

A number of factors are believed to be of critical importance in determining the way in which a child reacts to and assimilates the experience. These factors include the child's age and developmental status, the relationship of the abuser to the child, the amount of force or violence used by the abuser, the degree of shame or guilt evoked in the child for his or her participation, and, perhaps most importantly, the reactions of the child's parents and those professionals who become involved in the case. Most authorities agree that, other things being equal, the psychological trauma to the child is greater when the perpetrator of the abuse is close to the child than when he is a stranger (however, in a recent study by Finkelhor<sup>44</sup> the connection between the degree of trauma and the relationship between victim and perpetrator was unclear). The closer the relationship between child and perpetrator, moreover, the more likely is the sexual abuse to be repeated.<sup>45</sup>

It is not difficult to understand why some incidents of sexual abuse by a stranger may be far less traumatic than those committed by someone close to the child. In most such instances, the parents will rally to the aid of the child, and,



while they may overreact to the situation, their anger and feelings of retribution are generally directed toward the perpetrator. It is less likely that provocation on the part of the child will be suspected, and the child will generally receive expressions of concern, protection, and support from family and friends. The degree of violence or physical coercion used by the perpetrator is, of course, another important factor: if a child has been raped or otherwise physically harmed by an outsider, both the short- and long-term effects may be very serious.<sup>46</sup>

Intrafamily sexual abuse, including that initiated by persons whom the child or other family members hold in high esteem, usually has far more complicated temporary and long-term repercussions. The public disclosure of incest may awaken feelings of guilt associated with denial and depression. If the mother has been aware of the situation, she may deny any knowledge of the matter, accusing her daughter of lying. The father's guilt, shame, and fear of retribution also may overwhelm any concern for his daughter's feelings. Thus, the child may be rejected by both parents, perceived as guilty, and seen as a betrayer of her family. Under these circumstances, many children retract their stories. Often, it is only after the incest is discovered that the larger family problems may surface (and vice versa).

The effects of incest also depend on the child's age and level of emotional and intellectual development. Very young children may be less affected by an incestuous relationship than older children, because they may not have incorporated society's concepts of right and wrong, and lack awareness of the possible repercussions. If the sexual behavior between adult and child has persisted over a long period of time, if it has involved a series of progressively more intimate incidents, or if the child is old enough to understand the cultural taboo of what has occurred, then the effects may be more profound.<sup>47</sup>

Short-term effects of sexual abuse or its disclosure can take many forms. Some children react by regressing to earlier behaviors such as thumb sucking or becoming afraid of the dark; others sleep walk or develop difficulty in eating and sleeping. Sexual abuse may cause extreme anxiety which may be seen in excessive fears, enuresis, or tics.<sup>48</sup> Such physical symptoms may constitute the child's way of acting out disturbing feelings and reactions that cannot be verbalized. A fre-

quent symptom is the lack of inhibition of sexual impulses in the victim, who may seek love through sexual contact. Often, this behavior will result in the recurrence of sexual abuse to the child victim in the foster home.<sup>49</sup>

Less is known about the long-term effects of incest and sexual exploitation because much of the research is clinical, based on small numbers of cases, and retrospective. Although retrospective studies have documented a relationship between reported incest history and the development of promiscuity or prostitution, other authors decry the use of "failure to marry, or promiscuity" as the only accepted criterion indicating that a victim has been harmed.<sup>50</sup> The fact that many women reveal their incestuous history while involved in therapy for other problems, suggests that the damage from child sexual abuse may be related to other problems for which they are seeking help. Depression and confusion about their own identities are common reactions of many victims. Some jump into early marriages as a means of escaping their family situations and dealing with their feelings of aloneness. Some report feeling "marked" or stigmatized for life and may have suicidal tendencies.<sup>51</sup> Many victims of incest come to the attention of the courts for antisocial behavior and may go through the entire justice system without ever revealing their underlying problems.<sup>52</sup> There is no doubt, therefore, that in some cases incidents of child sexual abuse influence the personality and behavior of the victim for the rest of his or her life. Possible long-term effects include the repetition of self-destructive behavior patterns, such as drug or alcohol abuse, self mutilation, and the development of symptoms such as frigidity.

Clinical experience suggests that many of the children and adolescents exploited sexually for prostitution or for the production of pornographic materials were victims of incest or are runaways fleeing a developing incestuous situation. It is likely that a history of being sexually exploited by family members increases a child's susceptibility to sexual exploitation by others, particularly when the child is a runaway.<sup>53</sup> For some, the exploitation of their own sexuality is the only way they know to relate to others.

The effects of participation in the production of child pornography on the children involved have not been studied. It has been suggested that the victim may suffer psychological scarring and



emotional distress from the humiliating nature of the activity.<sup>54</sup> There is greater certainty that the children involved in the production of pornography are joining other deviant populations such as criminals, drug abusers, and prostitutes.<sup>55</sup> Given the wide range of possible experiences which a child might have in these circumstances, it is not likely that any one particular effect will be seen in all or even most of these children. However, it is obvious that (in the words of the U.S. Senate Judiciary Committee) the effects of this type of exploitation and degradation cannot but be "very harmful to both the children and the society as a whole."<sup>56</sup>

### *Intervention*

The reactions of parents, members of the child's community, and intervening professionals to the sexual abuse of the child are of crucial importance in determining its psychological effects on the child. Indeed, one researcher asserts that "the greatest potential damage to the child's personality is caused by society and the victim's parents, as a result of 1) the need to use the victim to prosecute the offender [to whom the victim may be deeply attached, as in the case of an incestuous parent], and 2) the need of parents to prove that the victim did not participate voluntarily and that they were not failures as parents."<sup>57</sup> Some parents respond with greater expressions of concern about the disruption of their own lives caused by the occurrence than with concern for the child victim. Self-oriented responses by parents have been found most often in those cases in which the offender was a member of the victim's household.<sup>58</sup>

The emotional trauma associated with sexual abuse may also be vastly increased or even overshadowed by insensitive professional intervention, particularly in the crisis intervention phase. The medical examinations routinely performed by some hospitals on children suspected of having been sexually abused may be experienced by the child as an intrusion as threatening as or more threatening than the initial incident. The legal process, particularly if it culminates in a court trial, can also be emotionally damaging to the child victim of sexual abuse. Due to the seriousness of the crime in many states, accusations by children are often viewed with a great deal of suspicion. As has been the experience of many

rape victims, the child victim may find that his or her credibility is in doubt.

One study examining the reactions of adult women and teenage girls who were victims of incest specifically refers to the intervention procedure, as it is often practiced, as the philosophy of "harass and then help." The family becomes embroiled in confusing procedures that pull it in different directions rather than making it healthy. Both groups of women in the study deplored the current criminal investigatory approach, and a few even said that they would not have reported or would have lied if they had known what would follow. Apart from recommendations on the long range help for these women, the study affirms legal intervention, and recommends cooperation from the press in keeping these matters private.<sup>59</sup>

In cases of incest, the pervasive fears of family disruption following disclosure are often well-founded. In many communities, particularly those without adequate social service resources, family separation is the only means available to protect the child. The children may be placed in foster care; the father may lose his job or be sentenced to prison; the family's income is jeopardized; the child feels guilty and may be blamed for the breakup of the family; and the family is disgraced in the eyes of the community. The potential for disastrous consequences undoubtedly accounts for much of the resistance to reporting incest. Given the fact that offenders usually do not receive any treatment in jail, the father may return to the home, again placing the child and his or her siblings in danger. Or, it may happen that the untreated mother will become involved with another man who repeats the same behavior.<sup>60</sup>

Signs of a change from punishment-oriented intervention in incestuous families to intervention with the goal of rehabilitating the family have begun to appear in some communities. This approach, when it is in the best interests of the child, is both hopeful and consonant with the trend toward family rehabilitation as the primary goal in child abuse and neglect intervention. There is an increasing awareness that the wrong kind of intervention can do more harm than good, and that the child often does not want to be permanently separated from his or her family. Therefore, more sympathetic, sensitive techniques for working with these families have begun to be developed.



Some communities have developed specialized teams for short-term, crisis oriented counseling with families that last from the reporting of the sexual assault until the family is handed over to the responsible agency for long range treatment. One such program, similar to the treatment model originally developed by Dr. Henry Giarretto in Santa Clara County, California, is the Boulder County (Colorado) Sexual Abuse Mini Team, consisting of a staff of three social workers. Each member of the family is interviewed by a team member of the same sex, and the entire family interviews on the same day, so that stories cannot be changed through the pressure of any family member. Since the offender is usually the father, the key to the program is the interview with him. In exchange for pleading guilty the father becomes eligible for the treatment program, and is offered the following advantages: the arraignment arranged at his convenience, no publicity regarding the crime and his family, avoidance of a criminal trial for himself and his family, and the possibility of probation in exchange for participation in a treatment program. The thrust of this approach is to test and measure the father's level of denial, an indicator of his willingness and ability to be treated, while counseling the victim and her family in the interval preceding long range treatment. Preliminary results from this program have been very encouraging.<sup>61</sup>

Another innovative program, used at the University of California Irvine Medical Center, delineates the pediatrician's role in the intervention process. In the past, the short-term management of sexually abused children was concerned with the collection of evidence and, therefore, was oriented toward the gynecologist. In the present program pediatric residents provide emergency and follow-up treatment within specified guidelines of performance in an atmosphere of emotional support and proper role models. It is hoped that the program will enable residents to provide high quality service to sexually molested children when they are in practice.<sup>62</sup>

### *The Legal Response to Child Sexual Abuse*

Statutory responses to the sexual abuse of children have included a wide variety of developments in child abuse and neglect reporting laws, in penal codes,<sup>63</sup> and more recently, in laws specifically aimed at child exploitation for pornog-

raphy and prostitution. Since 1978, much of the state-level legislative activity concerning protection of children from sexual abuse and exploitation has dealt with determining and providing for appropriate jurisdiction for such cases and with clarifying the statutory definitions of sexual abuse of children so as to afford better protection to the child.

In many states, criminal laws, such as incest and rape statutes, fail to provide specifically for the sexually abused child. All cases brought under these statutes fall within the jurisdiction of the criminal court since no provision is made for juvenile court child protective intervention in cases involving children. The use of the criminal courts, however, encourages intervention by law enforcement agencies rather than child protective service (CPS) agencies, and the adoption of an approach oriented toward the punishment of the offender, rather than a family- or child-centered approach oriented toward treatment and rehabilitation.

Both criminal and juvenile courts have specific procedures for handling cases involving children, such as removing the child from the home, ordering agencies to provide treatment for the child and family, avoiding the necessity for courtroom testimony by the child, and permitting a judge to question a child in chambers out of the presence of the parents. The focus of the two courts, however, differs significantly. The criminal court procedure centers on the conviction and punishment of the offender, while the concerns of the juvenile court are the best interests of the child. The juvenile court, because of its different focus and procedures, is more likely to have access to support services for effective supervision and treatment and to be able to handle cases with more flexibility.

The use of the criminal courts, on the other hand, may be more suitable for cases where physical injury is involved, or where the offender's behavior is compulsive, repeated, or sociopathic. Through conviction, the criminal courts can assure the offender's removal from the home. In addition, prosecution or the threat of prosecution can be a powerful incentive for the offending parent to change.

As was noted previously in the section on definitions, in 1978 the U.S. Congress amended the Child Abuse Prevention and Treatment Act of 1974 (P.L. 93-247) to include within the defini-



tion of child abuse and neglect "sexual abuse or exploitation...by a person who is responsible for the child's welfare..." and to provide further definition for sexual abuse and exploitation. Many states also have broadened the concept of reportable abuse to include sexual abuse and exploitation, although most still leave sexual abuse undefined in their reporting law or refer to the state's criminal or other statutes for the definition of sexual abuse. A few, including Maryland and Nevada, have specifically defined these terms in their reporting law. For example, in Nevada's reporting law, sexual abuse includes, but is not limited to, incest, lewdness with a child, annoyance or molestation of a minor, sadomasochistic abuse, sexual assault, and statutory sexual seduction.<sup>64</sup>

Florida has broadened its definition of abuse to include an operational definition of sexual exploitation:

"Abuse" or "maltreatment" also includes the aiding, abetting, counseling, hiring, or procuring of a child to perform or participate in any photograph, motion picture, exhibition, show, representation, or other presentation which, in whole or in part, depicts sexual conduct, sexual excitement, or sadomasochistic abuse involving a child.<sup>65</sup>

In the past three years an increasing demand for the protection of children from sexual exploitation has created an upsurge in legislative activity dealing with the problem. Congressional hearings have been held and bills have been introduced both in the Congress and in state legislatures. Some state measures seeking to outlaw child pornography materials without having to prove them obscene have run afoul of First Amendment safeguards. Some efforts have concentrated on the producer of pornography as a child abuser, while others have concentrated on both producers and distributors. Violations of obscenity statutes, which formerly were ruled misdemeanors, have been changed to felonies when children are involved, and some states are contemplating increasing the severity of penalties as the age of the child victim decreases. California requires retailers as well as distributors of child pornography to keep records of their suppliers for a three-year period, even though such registration raises serious

constitutional questions involving Fifth Amendment protection of defendants testifying against themselves.<sup>66</sup>

The new Federal law dealing with the sexual exploitation of children, the Protection of Children Against Sexual Exploitation Act of 1977 (18 U.S.C., Sections 2251-2253), incorporates the term "obscene" into the legislation designed to control child pornography, thus bypassing the constitutional hurdles of the First Amendment. The bill incorporates a double approach, penalizing producers of child pornography as child abusers, while focusing on the legal issue of obscenity with distributors and retailers of sexually explicit material involving children. The new law prohibits any child under sixteen from being used by a producer in any sexually explicit manner. In addition, the Mann Act of 1948 (18 U.S.C. Section 2423), which was originally enacted to prohibit the interstate transportation of girls under eighteen years of age for purposes of prostitution, has been expanded to include boys. The delicate balance between First Amendment guarantees and legislation seeking a firmer grip on the child pornography problem is sure to be tested in the courts for quite some time.<sup>67</sup>

#### *Prevention and Treatment*

Several programs utilizing intensive family and group therapy have recently shown that incestuous families need not be destroyed in order to protect the child. One of the most successful is the Child Sexual Abuse Treatment Program operated by the Santa Clara County (California) Juvenile Probation Department. The therapeutic approach of the program is based on the theory and techniques of Humanistic Psychology. The family is treated primarily as a system, and the intent of therapy is to foster personal growth and the development of self-responsibility in family members. No recidivism was reported in a sample of families who had been in treatment about 14 months. Because of the program, children are returned to their families sooner; the self-punishing behavior of the children has been reduced; more of the marriages have been saved and improved; the rehabilitation of the perpetrators has been accelerated; and normal relationships between father and daughter have been restored. The program has also been involved in public education and professional training.<sup>68</sup>



A number of other programs have been developed throughout the country to demonstrate and explore new ways of helping incestuous families to function in a more healthy, child-oriented way. Some work closely with the police and the courts, and others have taken a social service approach to keeping the family out of the criminal justice system. Some are primarily focused on helping incest victims understand that it was adults, not they, who were responsible for the abuse; others provide their primary support to mothers who are trying to decide whether to maintain their marriage relationships; some are focused on medical aspects and the hospital's role in constructive intervention; and others emphasize a group work or self-help approach to treatment. Regardless of their particular focus or orientation, most programs recognize that the treatment of incest must involve a family systems approach.

Many authorities have criticized the lack of research in the area of treatment outcome.<sup>69</sup> Very little literature exists with samples of sufficient size which objectively measure change in patients before and after treatment. Furthermore, there have been only minimal attempts to compare the behavioral, psychoanalytic, counseling, or penal approaches to treatment of offenders or their families.

Better treatment programs and their evaluation are obviously only one means of improving our system for dealing with child sexual abuse. Attention must be focused on the needs of children and families from the time that an abuse situation is discovered. Special units or teams of professionals in hospitals, police departments, and social service agencies must be trained to deal with child sexual abuse and to become sensitive in their interactions with children. Whenever possible, cases should be handled by social workers or plainclothes police officers, since children are often frightened by police officers in uniform.

The reality of existing legal and medical procedures, however, cannot be ignored. Criminal laws that involve the child witness will not be disposed of simply because they make therapeutic intervention difficult. They must be changed where they are destructive or insensitive to their effects on children, and, where families are involved, they must be humanistically refocused on rebuilding rather than destroying. Children should undergo a minimum of interviews about what happened and necessary medical examinations

should be performed with the utmost sensitivity and care. Every attempt should be made to handle court cases in pretrial conferences, judges' chambers, or special closed settings. In addition, these cases require careful diagnosis and followup to determine what long-term effects the abuse may have. Whether children are abused by strangers or by someone they know well, they need to be treated with compassion and understanding.<sup>70</sup>

To a great extent, the actual treatment method or approach with incest victims may be less important than the incorporation of basic concepts that reflect the dynamics of this abuse. Since trust in authority figures may have been shaken by the incestuous experience, the victim must be convinced that the helping person is dedicated to ending the sexual abuse, and that the helping person finds the victim important. To overcome feelings of powerlessness and to shake off the effects of sustained manipulation, the victim must be believed, supported, and cared about. She or he must be free to express continued anger, hurt, disgust, or ambivalence towards both parents. Because her parents see her behavior as bad, and because the victim may have let the abuse go on for a period of time, the helping person must provide the opportunity for the victim to express the guilt and responsibility that she feels, in an atmosphere of trust.<sup>71</sup>

Successful treatment of incestuous families may constitute an important component of primary prevention for the generations to come; as noted above, incestuous family configurations tend to repeat themselves in a generational cycle. Not only does the mother require strong maternal role modeling to avoid abuse in the present, but the victim needs to understand the maternal role so that she does not become a mother of an incest victim in the future. It is crucial, therefore, that any long-range attempt to reduce the incidence of incest focus on family rehabilitation as opposed to mere legal intervention.

The availability of telephone helplines has been an important step in the direction of prevention, both primary (before the fact) and secondary (after the fact) - as it has in the prevention and treatment of child abuse and neglect in general. In Knoxville, Tennessee, a 24-hour taped telephone message on sexual abuse makes counseling available by telling callers, "if you need help, stay on the line." In the first month that this service was available, 40 of the hundreds of callers

stayed on the line to talk to a counselor about a sexual abuse problem. Twenty-five of the callers were adolescents.

Prevention may also be helped, in the long run, by teaching children about their bodies and about appropriate sexual behavior. An education in sexuality and physiological response could alleviate much of the guilt children may experience in being unable to control the response of their own body. Being taught how to say "no" and how to ask for help when they need it could also help many children to defend themselves against sexual abuse. Feminists have stressed that just as consciousness raising has often been more therapeutic for women than psychotherapy, so too could the open and public discussion of incest by women benefit not only those suffering from incest, but those who may be exposed to the danger in the future.<sup>72</sup>

Prevention in specific cases (in families at high risk of incest) is rare because of the difficulty in detecting such families. Early signs of trouble are difficult to differentiate from other acting-out behaviors, and professionals must not only be alert to the veiled messages of children, but must encourage children to express their feelings openly. However, developing cases do not often come to the attention of those qualified to intervene or able to recognize the signs of trouble. In the words of Dr. Suzanne Sgroi, *"recognition of sexual molestation in a child is entirely dependent on the [professional's] inherent willingness to entertain the possibility that the condition may exist."*<sup>73</sup> The training of professionals to identify sexual abuse victims, the education of parents and children, and changes in societal attitudes are all necessary if prevention is to be successful.



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## RATIONALE:

Intrafamilial child sexual abuse is a form of child maltreatment which involves different dynamics, different case-finding and different procedures of child protective intervention. While it is covered by child abuse and neglect reporting laws and can be handled as a juvenile (civil) court matter, child sexual abuse is also included under criminal statutes as a sex offense and cases may be taken to criminal court for prosecution of the perpetrator. The response of those who discover cases, of the agencies involved in handling them and of the community at large may be more reflective of personal attitudes toward the crime than of concern for the protection and emotional well-being of the child victims.

### Definition

Intrafamilial child sexual abuse may be defined as contacts or interactions between a child and an adult in which the child is being used for the sexual stimulation of the adult or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over another child.

### Victims-Perpetrators

While the victims of intrafamilial sexual abuse may be boys and the perpetrators may be adult women, most reported cases involve girls and fathers, father-substitutes or other male adult family members. It may be that boys are more reluctant than girls to report. The average age of children in one study conducted by the American Humane Association was 11 years. Many treatment projects report that the abuse actually begins several years earlier.

### Adult use of child for sexual gratification

Physically violent sexual abuse within the family, such as rape and sadism, is rare. Usually the context of the abuse is a parent-child relationship, which may begin "innocently" as special physical attention from the parent figure and develop into a relationship of adult sexual gratification at the child's expense. In some but certainly not all cases, the mother is aware of the sexual abuse but denies or ignores its existence.

## Possible underlying characteristics

The family dynamics that contribute to sexual abuse of a child are complex. The underlying characteristics may include:

- A father or stepfather who is ineffectual, has low self-esteem, and is unable to relate adequately to other adults. He may be an autocratic ruler of the family.
- An unhealthy marital relationship, in which the adult sexual relationship is either strained or nonexistent.
- Prolonged absence or loss of one parent.
- Severe overcrowding.
- Lack of social and emotional contacts outside the family.
- Geographical isolation.
- Alcoholism.
- Precipitating crisis in adult's life with a resulting loss of self-esteem.
- Presence of an extremely passive parent.
- Cultural attitudes and multigenerational patterns of incest.

### Physical Indicators

(Nonmedical observation)

- Pain, itching, bleeding in genital area.
- Torn or stained clothing.
- Genital, anal or oral bruises.

(Medical observation)

- Genital, anal or oral bruises.
- Genital, anal or oral bleeding.
- Swollen or red cervix, vulva or penneum.
- Semen on genitals or clothing.
- Venereal disease—oral/genital.

(See Optional Activity 5 below)

Behavioral indicators include:

- Regressive or fantasy behavior, night fears.
- Extreme withdrawal or aggression.
- Sexual acting out or promiscuity.
- Poor peer relationships.
- Fear of opposite sex.
- Extremely protective parental behavior.
- Avoidance of physical activity.
- Running away from home.
- Drug abuse.
- Self-destructive behavior/self-mutilation.
- Indirect allusions to problems at home.
- Psychosomatic illnesses.

The effects on the child of sexual abuse vary depending upon factors such as:

- Child's age and developmental status.
- Relationship of the perpetrator to the child.
- Amount of force or violence used.
- Degree of shame or guilt evoked in the child for her participation.
- Reactions of the parents to the discovery.
- Reactions of those professionals who become involved in the case.

While the physical and emotional trauma caused by sexual abuse itself may vary, it is clear that the way professionals handle a discovered case can have lasting effects on the child and the family. The community's outrage at child sexual abuse may be translated into criminal prosecution that depends upon evidence given by the victim. A frightened child becomes the center of a storm of family and professional intervention which threatens to disintegrate her family in the interest of protecting her from further sexual abuse.



## INTRAFAMILY SEXUAL ABUSE OF CHILDREN

### I. DEFINITION

- A. Sexual intercourse
- B. Sexual stimulation

### II. UNDER-REPORTING

- A. Strong societal taboo thus denial
- B. Professional denial of problem
- C. Occurs within home

### III. UNDERLYING FAMILY CONDITIONS

- A. Parent sexually misused as a child
- B. Family breakdown
- C. Parental low self-esteem
- D. Characteristics within family
  - 1. Prolonged absence of one parent from the home
  - 2. Loss of one parent through death or divorce
  - 3. Mental problems
  - 4. Alcoholism
  - 5. Lack of social or emotional contacts
  - 6. Geographical isolation
  - 7. Cultural standards determining degree of bodily contact

### IV. INDIVIDUAL PROFILES

- A. Adult Male
  - 1. Rigid disciplinarian
  - 2. Passive out of home
  - 3. Little social mingling
  - 4. Jealous and protective of child

### B. Mother

- 1. Knows of situation
  - a. Denial
  - b. Fear
- 2. Prefers it to husband "running around"
- 3. Relief from wifely sexual responsibility
- 4. Guilt and jealousy toward child

### C. CHILD

- 1. Feels guilt as she reaches teen years
  - a. Frigidity
  - b. Promiscuity
- 2. Continuous sexual activity
  - a. fear of father
  - b. fear of destroying family unit
  - c. protect younger sisters
- 3. Guilt reinforced by removing child

### V. PHYSICAL INDICATORS

- A. Bruises—genital or anal
- B. Bleeding—vaginal or anal
- C. Swelling or redness—cervix, vulva, perineum
- D. Sores
- E. Venereal disease

### VI. BEHAVIORAL INDICATORS—CHILD

- A. Regression
- B. Delinquency or aggression
- C. Poor peer relationship
- D. Avoidance of physical activity
- E. Running away
- F. Drug usage
- G. Indirect allusions to problems at home

|                                    | Primary                                                                                                                                                             | Secondary                                                                                                                                              | Latent                                                                                                                      | Late                                                                                                                   |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Symptoms</b>                    | The primary stage is characterized by the chancre (an ulcer-like lesion) which may be seen on genitalia or mouth or rectum. The chancre is rarely seen in children. | If the chancre is untreated, the secondary stage occurs. Symptoms include fever, sore throat, rash, lymph gland swelling, and liver or kidney disease. | There are no latent stage symptoms                                                                                          | Late Stage symptoms can include neurological disease, cardio-vascular disease, benign tumors, blindness, and insanity. |
| <b>Duration of symptoms</b>        | The primary stage symptoms appear 10-90 days after exposure, with an average incubation period of 21 days. The chancre may be persistent for 4-6 weeks.             | Secondary stage symptoms may appear six weeks to six months after the chancre and last up to one year after the onset of the disease.                  | The latent stage begins after the secondary stage is resolved and may last for the life of the patient.                     | The re-emergence of symptoms marks the beginning of the late stage.                                                    |
| <b>Lab Tests</b>                   | Serologic tests will probably be negative. Darkfield examination should be positive.                                                                                | In approximately 100% of cases, the serologic test will be positive. Darkfield examination of skin lesions will be positive.                           | Serologic tests will be positive. The absence of skin lesions precludes Darkfield examination. Spinal fluid will be normal. | Serologic tests will be positive. A spinal fluid examination may be positive.                                          |
| <b>Communicability</b>             | The chancre is highly infectious.                                                                                                                                   | The lesions of this stage are highly infectious.                                                                                                       | The patient is possibly infectious. The patient's blood is highly infectious.                                               | The patient usually is not infectious after four years (except infection of a fetus by a diseased mother).             |
| <b>Prognosis</b>                   | The patient can be successfully treated.                                                                                                                            | The patient can be successfully treated.                                                                                                               | Treatment is successful in the early latent stage.                                                                          | Treatment can ameliorate the effects of organic lesions caused by the disease.                                         |
| <b>Risk of Infection</b>           | The patient is vulnerable to reinfection from a subsequent exposure.                                                                                                | The patient remains vulnerable to reinfection from a subsequent exposure.                                                                              | When treated in the early stage the patient may be vulnerable to reinfection from a subsequent exposure.                    | The patient probably is no longer vulnerable to reinfection.                                                           |
| <b>Destructive Organic Lesions</b> | No                                                                                                                                                                  | No                                                                                                                                                     | No                                                                                                                          | Yes                                                                                                                    |

#### Symptoms of Gonorrhea

|                             | Males (any Age)                                                                                                                                                               | Females (pre-pubertal)                                                                                                                                                  | Females (adult)                                                                                                                     |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <b>Incubation Period</b>    | Average 3-5 days                                                                                                                                                              | Probably same as males                                                                                                                                                  | Probably same as males                                                                                                              |
| <b>Symptoms</b>             | <ul style="list-style-type: none"> <li>• pain on urination</li> <li>• penile swelling</li> <li>• penile discharge</li> <li>• inflammation of the head of the penis</li> </ul> | <ul style="list-style-type: none"> <li>• pain on urination</li> <li>• vaginal discharge</li> <li>• urethral inflammation</li> <li>• lymph gland inflammation</li> </ul> | <ul style="list-style-type: none"> <li>• inflammation of urethra, cervix, glands of the genitalia</li> </ul>                        |
| <b>Asymptomatic Disease</b> | Occurs in 10% of males                                                                                                                                                        | Statistics specific to this group not available                                                                                                                         | Occurs in 75-90% of females                                                                                                         |
| <b>Complications</b>        | <ul style="list-style-type: none"> <li>• fever</li> <li>• rash</li> <li>• arthritis</li> </ul>                                                                                | Usually none                                                                                                                                                            | <ul style="list-style-type: none"> <li>• painful inflammation of tubes</li> <li>• inflammation of uterus</li> <li>• rash</li> </ul> |





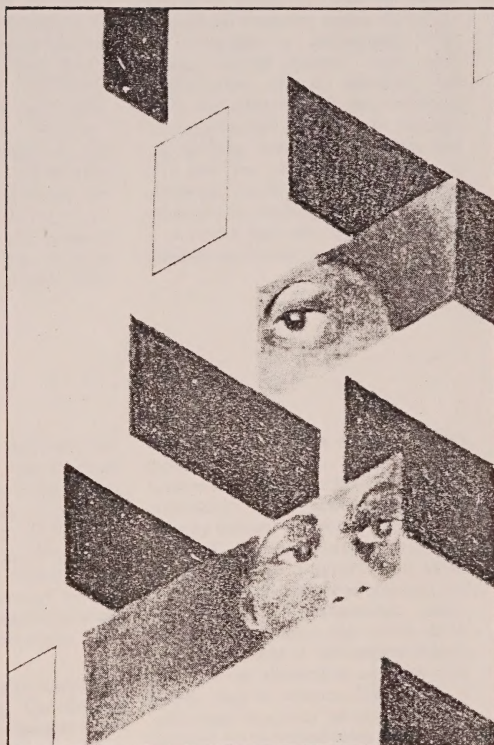






# How Women Recover: Experience and Research Observations

**Editor's Note:** In December 1981, representatives of 40 of the 45 women's treatment programs funded during the preceding 11 years by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) met in Minneapolis to discuss the knowledge gained from their experiences in treating women with alcohol problems. NIAAA is no longer funding alcoholism services programs, but rather is mandated to focus efforts on alcoholism research and information dissemination. This article is excerpted from a monograph based on the conference, and includes a summary of the observations of the conference participants and the complete text of the final chapter of the monograph, which reports on research literature related to women's treatment issues raised by conference participants. Joan Volpe, Ph.D., was the author of the final chapter. Gayle Hamilton and Volpe were the primary authors of the monograph. Margaret Wilmore of NIAAA was the coordinator of the conference and monograph. *Advances in Alcoholism Treatment Services for Women* is expected to be published later this year.



## Conference Objectives

In the 1970s the National Institute on Alcohol Abuse and Alcoholism (NIAAA) met the challenge of treating women with alcohol problems by establishing program guidelines and funding women's centers. In the ensuing years, 45 programs were funded to provide services to women with alcohol problems. Considered, in part, as an experiment focusing on treatment needs of a particular, albeit heterogeneous population, the Institute felt the impetus to gather information about the progress of these programs.

Policy changes have shifted the administration of alcoholism services programs from the National to the State level of operation. As a result,

NIAAA is no longer funding service programs. Partly because of a desire to trace the history of its funded women's programs and partly because of its new role in research and information dissemination, NIAAA staff set out to collect experiential data from the field regarding the treatment of women with alcohol problems.

The most useful and comprehensive method for gathering and examining such experiential data seemed to be to convene a national conference of directors of the NIAAA-funded women's treatment centers. The conference was designed to achieve maximum participation through the use of small workgroups. Five major themes were selected by NIAAA staff and the

women's programs as the most significant areas for exploration. The topics included outreach and identification issues; treatment issues and practices; aftercare planning; the importance of community/State support; and evaluation/outcome criteria.

The 38 women's programs represented at the Minneapolis conference varied in terms of urban/rural geographical setting, type of treatment, administrative structure, and subpopulations of clients served. While not evenly distributed throughout the country, programs were located in the northwest, west, southeast, central, and northeast areas, and in urban, suburban, rural, and reservation communities. They served white, black,





Hispanic, and Native American women and their families. The majority of clients were low and middle income women.

A wide range of services were provided by the programs through both freestanding and umbrella agency structures. The treatment settings included hospital/clinic, residential, halfway house, outpatient, or daycare. Some operated within coed facilities, but the vast majority were exclusively women's programs. Several programs provided residential service for women and their children. Each of the partici-

pants reported on a wide range of experiential data; however, the observations at the conference cannot be considered as representing the needs of all women clients, even in these 38 programs. Nevertheless, the information is useful for the field because it represents present "clinical wisdom." Within a context of widespread dissemination efforts, the information developed from the conference can serve a number of functions for a variety of service providers and training organizations. For programs yet to be established, there is important infor-

mation about community planning, treatment planning, staffing needs, and special women's issues. For existing programs in alcoholism, drug abuse, mental health, and other health/social service agencies, the ideas and observations may provoke new approaches to outreach, marketing/funding, treatment planning, and aftercare for women with alcohol problems. For State and local agencies interested in training and in research, it is hoped that the information will stimulate planning in this area.

## Major Themes

Two themes were repeatedly expressed by participants at the Minneapolis conference. The first theme related to women's programming that was seen by participants as holistic in nature. The second theme focused on women's concerns, reflected in the culture in general, that heavily affect all program activities. In reviewing the specific issues and strategies that emerged from the conference discussions, it is clear that these programs are living their ideologies.

In all five of the conference topic areas, participants maintained a broad definition of the purposes of their activities, transcending textbook definitions. The impression created by the participants was that of an expanded vision of alcoholism treatment that had arisen out of the necessity of dealing with a very complex set of societal issues. Such issues make it impossible to deal in a parochial manner with casefinding, treatment, or provisions for ongoing support to women alcoholics. Cultural mores seem to protect women while rejecting women alcoholics. Therefore, programs treating the problems of alcoholism in women must address sociocultural attitudes and role prescriptions. Furthermore, many of these programs have clients from minority racial groups and alternative lifestyles who are subject to additional stereotypes and stigma. The

fact that the programs are predominantly administered by women tends to create discomfort in communities unaccustomed to seeing women in senior management roles. The service load of the programs is largely dependent on community resource personnel whose understanding of the programs' purposes, clientele, and directors may be clouded by myths, stereotypes, and fear.

Thus, *outreach activities* cannot be limited to casefinding. Casefinding itself is dependent upon changes in attitudes among professional caregivers, among friends and acquaintances of the female alcoholic in the community, and among spouses, and in attitudinal changes toward self among women in the community who have drinking problems. This includes changes in attitude not only toward the female alcoholic but also toward women in general. Outreach activities, therefore, include extensive community and professional education.

*Treatment activities*, according to participants, cannot be limited to recovery from alcoholism and the kinds of inner growth work characteristic of traditional mental health programs. Treatment activities in women's alcoholism programs must also address the personal limitations brought about by role constrictions. Participants stressed that, in order to successfully treat the alcoholism, the

behavioral repertoire of their clients must be broadened. Areas for development must include behaviors considered to be appropriate for a healthy person, regardless of sex. This includes an emphasis—heretofore lacking in coed programs—on assertiveness, vocational development, and clarification of independent goals. Program staff must also work to repair the damage to self-esteem created by both the alcoholism and the roles clients play as women. Self-esteem is addressed in a truly holistic way, and includes an increased sense of well-being resulting from better health and increased capacity to manage stress; increased skills in communication and building relationships; a better understanding of sexuality; and increased competence in managing both independent employment and daily affairs.

*Aftercare* goes beyond the concept of merely providing ongoing support for gains made in treatment. According to participants, the very gains made in treatment may, in fact, create further stresses for clients, in that both family and community may respond negatively to the changes associated with recovery. Grief and sexual abuse are such deep and pervasive issues that frequently they are not addressed until the aftercare phase in treatment. In addition, participants noted an absence in the community of the sensitive, knowledgeable support systems





needed by women once treatment is completed. Therefore, even with limited staff resources, aftercare programs must often provide extensive crisis support, ongoing therapy in some cases, and community educational work to help create viable community support systems.

*Community involvement* for these programs has become a vehicle for marketing and fund raising, for gaining credibility as women-managed organizations, for changing community myths about their anti-male orientations, and for reducing general community fear about program purposes. Community involvement, then, includes lobbying, fundraising, providing educational workshops, obtaining media coverage, and responding in a helpful way to general community concerns bearing little relationship to alcoholism issues per se.

For these programs *research and evaluation*—specifically related to treatment outcome measures—include evaluation of issues far beyond just abstinence from alcohol. An evaluation of outcome must include changes in employment status (or changes in economic self-sufficiency); changes in management of home responsibilities, including parenting; changes in acceptance of personal responsibility; improved ability to deal with feelings, depression, sexuality, relationships, and assertiveness; increase in personal supports; increase in independence; and increase in cultural identity. While outcome studies are apparently important to the programs, participants' interest in research goes beyond knowl-

edge of treatment outcome. Topics raised at the conference for future research consideration are listed at the end of this article.

In addition to the fact that *each* of the topic areas reflects a holistic vision and relates to women's issues, it is also clear from the conference discussions that all of the topic areas (outreach, treatment, aftercare, community involvement) are interrelated and must be dealt with as a continuum of care. The issues discussed initially in the outreach workshop merged with issues that were discussed in each of the subsequent workshops. In fact, participants were sometimes frustrated by the discrete categories under discussion because it became difficult to subsume actual strategies used into single topic areas. At the program level, staff viewed treatment as a continuous process, and therefore, carried out each specific activity of their jobs with impressive clarity about both immediate and far-reaching effects and purposes.

An additional issue of interest that emerged from this conference is that there must be recognition of the delicate balance required by staff if these women's centers wish to reach program goals. In order to get women to enter the programs, staff must significantly change public attitudes toward women and women alcoholics. Yet staff must be sufficiently identified with the local cultural norms to acquire the trust and respect needed to become accepted as a viable organization in the community. In order to effect healthy sobriety and create a

more androgynous repertoire of behaviors, staff must encourage the broadening of their clients' sex role perspectives. Although this is perceived by staff to be important for the women's recovery, it sometimes causes the client to experience considerable fear and anxiety. Furthermore, persons important to clients may respond negatively. Such situations necessitate that staff be especially sensitive to the potential stresses that treatment itself produces.

It is hard to ignore the paradox faced by a woman who wishes to be an achiever in our society. High achievement may arouse fear and rejection of her role as a woman; acceptance as a woman sometimes requires foregoing personal goals of achievement. Attainment of both requires maintaining a very sensitive and delicate balance in behavior and attitude. Perhaps the directors of the women's centers represented at this conference, most of them women, are exceptionally well suited and trained for the roles they must now play. And perhaps these difficult roles have created the imperative that women's center directors feel toward extensive staff training and establishment of a consistent staff philosophy toward all aspects of women's programming. Certainly, clarity surrounding their goals with clients and community, and clarity about the far-reaching effects of all program activities, serves to reduce the anxiety that must be a part of managing such a complex set of strategies.

## A Research Perspective

Perceptions of the path to sobriety vary among alcoholic persons experiencing recovery, counselors assisting in the recovery process, and researchers investigating recovery patterns. Yet, somehow, interpretations must be made that offset these varying perceptions if we are to uncover the basic underlying

themes associated with the etiology and treatment of women's alcoholism.

Currently, our understanding of alcoholism comes both from data gathered by researchers that may or may not include clinical research and from the experiential knowledge of therapists and recovering alcoholics. Clearly, information gleaned in one

source is not in diametric opposition to that gathered in another, but somehow the two arenas of research and treatment have not been steady companions in the long search for enlightenment about women's alcoholism.

Over the past 11 years, attention has been given to the problems of women and alcoholism through the funding





efforts of NIAAA. During these years a total of 45 treatment programs were funded to address the recovery needs of female clientele. The majority of these women's treatment programs have been in operation from 3 to 6 years. The most senior programs were started 10 years ago.

A careful scrutiny of available research data makes it clear that, although we have amassed a body of literature about alcoholism, alcoholics, and alcoholism treatment, it is still unclear whether what we now know is generalizable to various segments of the alcoholic population. This concern has particular relevance for the subpopulations of female alcoholics whose problems, until recently, were either ignored or viewed as congruent with alcoholism in men.

## Characteristics of Women Alcoholics

Reviews of the literature indicate that women alcoholics begin drinking at a later age than men, but that women appear for treatment at the same average age, which suggests a telescoping effect in women's alcoholism (Curlee 1970; Elder 1973; Glatt 1961; Lisansky 1957; Sclaire 1970; Wall 1937; Wanberg and Knapp 1970; Winokur and Clayton 1968). While conference participants did not attempt to compare the onset of alcoholism between men and women, there was general agreement that a telescoping effect was evident in their populations of alcoholic women.

As noted in the literature, case finding of women alcoholics has been particularly problematic (Blume 1978). Closet drinking, extreme feelings of guilt and shame, social rejection, and misguided protectiveness by caring persons have had the effect of isolating the female alcoholic. Caught up in a spiral of guilt, stigma, isolation, and protectiveness, women hesitate to seek help for their alcoholic problems.

Research findings show that the average age of women seeking treatment is around late 40s and 50s

By organizing a forum of program directors of the federally funded women's treatment programs, NIAAA has provided the alcoholism field with an opportunity for cross-fertilization of alcoholism information. In this section, attempts are made to link research findings on women with experiential information provided by the participants attending the Minneapolis conference. This research review is organized to reflect the issues and concerns of the program participants as they know and understand the needs of alcoholism in women. Therefore, this is an attempt to examine the similarities and differences noted between research findings and experiential knowledge, rather than a literature review. Topics discussed by the program participants are addressed

and findings relating to each of the topics are interspersed throughout the discussion.

The understanding of women and alcoholism presented here is based upon the experiences of the participants attending the conference and their perceptions of the needs of the particular groups of female alcoholics being served in their treatment centers. While very informative, and in many cases quite insightful, the experiential information is not generalizable to the total population of alcoholic women. Clinical wisdom expressed by these participants about specific groups of women alcoholics, however, provides pertinent information about the needs and issues of women alcoholics in similar circumstances.

(Cahalan et al. 1969) or between 40 and 50 at the time of hospitalization (Schuckit and Morrissey 1976). The representatives of the women's treatment programs represented in Minneapolis report a decline in the average age of their client population. Taking an active stance on casefinding, many of these programs have focused attention on the multiple needs of their target populations and on the special needs of some subgroups in that target population. Strategies for outreach are designed to address sociocultural differences of the subpopulations of women in each community. Marketing their programs through the media, raising community awareness of the problem of women and alcoholism, and forming alliances with professional groups and gatekeepers have served to improve casefinding and to bring women into treatment at an earlier age.

Although it was not possible to ascertain a composite average age of clients for the 38 programs in attendance, it is significant that most of the programs represented at the conference spoke of a declining average age.

With the advent of alcoholism treatment facilities focusing on specific needs of women, it appears that female problem drinkers are entering treatment at a younger age. Reasons given for the declining average age include substituting a holistic model of health for the more traditional image of alcoholism treatment, thereby reducing stigma, and increasing outreach efforts to teenage populations.

The age of clients entering treatment varied among subpopulations, according to the conference participants. One Native American program reports an average age of 28 for women clients. Program staff believe that the high rate of cirrhosis among this subpopulation of alcoholic women leads to early treatment referrals. Programs targeting Hispanic women continue to have problems reaching and treating that female population. Directors from these programs are aware that there are many women in the Hispanic community in need of alcoholism services, but resistance from Latin men continues to be a barrier to treatment. Until Latin men are more accepting of alcoholism treatment





facilities, programs with a target population of Hispanic women do not expect to see an appreciable decline in the ages of their clients.

**Early life disruptions.** Alcoholism in relatives and disruption in early life experiences are topics frequently noted in the research literature on women alcoholics. There seems to be a general agreement in research findings that incidence of alcoholism is higher in families of female alcoholics than in those of male alcoholics (Jones 1972; Winokur and Clayton 1967, 1968), or at least that there is a high incidence of alcoholism in relatives among women alcoholics (Jacob and Lavoie 1971; Johnson et al. 1966; Lisansky 1957; Wood and Duffy 1964).

Although no estimates were given by conference participants regarding the number of women in treatment having alcoholic relatives, their clinical findings are supportive of research data. Some of these programs indicated that not only is alcoholism high in the families of their clients, but it is not unusual to provide treatment to relatives of the alcoholic woman or to have a spouse or lover receiving treatment simultaneously from the parent organization or other local alcoholism agencies.

Findings on the association of early life disruption with alcoholism in women vary by social class (Curlee 1970; Kinsey 1966; Lisansky 1957) and by type of disruption (DeLint 1964; Rosenbaum 1958). While disrupted early life experiences appear to be related to alcoholism, family life disruptions caused by broken homes and psychopathology are also seen in psychiatric populations (Gomberg 1976, 1978). Therefore, disruption in early life may be considered a high-risk factor for later problem drinking, perhaps necessary but not sufficient to explain alcoholism. The question is why person A develops neurotic or antisocial behavior and person B develops alcohol problems, when both have had negative early experiences.

The topic of disruption of early life experiences for the female alcoholic arose intermittently throughout the Minneapolis conference. Since clinical findings regarding this topic were not



discussed with any consistency by the participants, it is impossible to draw conclusions as to whether early life disruptions are a significant feature in the drinking histories of the women in treatment at these facilities. Such disruption, furthermore, is not an essential component in rehabilitation which according to participants must focus on the here and now and current life crises.

While disruptive experiences in general were referred to with inconsistency at the meetings, emotional and physical problems resulting from incest and rape were frequently addressed. The majority of the program directors in attendance reported that many of their clients had been victims of incest or rape or both. Programs reporting clinical data of sexual abuse indicated that as many as 45 to 70 percent of their clients had been so victimized. One participant reported the rate of sexual abuse as high as 90 percent. These figures on the incidence of incest and rape may appear high when compared with available data in the literature. However, program representatives believe that this discrepancy exists because there are hesitations to reveal or to ask about the sensitive subject of sexual abuse. According to program directors, women alcoholics in coed treatment facilities hesitate to discuss sexual abuse in mixed company. Even in all-women's programs the client is often reluctant to speak of incest or rape until she feels a sense of security. Second, until questions regarding sexual abuse are asked on a regular basis by researchers and other clinicians, the information on incest and rape will remain hidden. It may be true that the women who enter alco-

holism treatment are more likely to be carrying a double burden—problem drinking and a history of sexual abuse—than are women alcoholics who are not seen by treatment facilities. For now, it is clear that clinicians are suggesting a hypothesis about the significance of early sexual abuse in the development of later drinking problems, and that researchers should be exploring that hypothesis.

**Precipitating events.** Many research reports indicate that women alcoholics are able to identify a specific incident in their lives that is associated with the onset of heavy drinking (Belfer et al. 1971; Burton 1973; Curlee 1970; Franck and Rosen 1949; Hoffman and Noem 1975; Lisansky 1957; Mulford 1977; Wilsnack 1973).

Writing in 1974, Gomberg suggested that this association of problem drinking and a stressful event or situation may in fact be a consequence of women's needs to justify alcoholic drinking, thereby reducing the stigma attached to female alcoholism. Schuckit and Morrissey (1979), studying a large sample of women, found that a particular stressful event was not given as an associated factor in the drinking histories of this population. Volpe's (1980) work with a group of halfway house women corroborates Gomberg's assumptions.

By and large, program directors at the conference agreed that an explanation of alcoholism in women that posits a major precipitating event is unfounded. It is true that many women in treatment speak of distressful events in their lives when they recount previous drinking behavior.





However, abusive drinking for most of these women predated the specific event(s) identified. On the basis of clinical experience, it appears that as rapport with counselors increases, clients' need to speak of a precipitating event decreases. Reducing the need to justify alcoholic drinking enables the women in treatment to look at the progression of her alcoholism. Writing of the societal censure of alcoholism in women and the need to shift responsibility to an outside event, Corrigan (1980) suggested, "Given our present state of knowledge . . . it seems preferable to understand the course of alcoholism as an ill-defined illness rather than to look for causation in a given life situation" (p. 158).

The need is for researchers to shift from an emphasis on traumatic events as precipitant toward the kind of epidemiological, lifespan research that studies trouble points or stress points in peoples' lives. Some current work suggests that younger women (under 35) may be more vulnerable to problematic drinking after separation or divorce and that, at all ages, women who work outside the home often feel harried by the demands of two roles and may turn to alcohol. The program directors, however, are suggesting that attention be shifted away from the *specific* precipitant.

**Biological features.** Medical disorders associated with women and alcoholism are frequently referred to in the literature. While each of the Minneapolis conference attendees could provide a laundry list of physical ailments suffered by their clientele, all were in agreement that the women alcoholics in their programs had a very high proportion of gynecological disorders. Studies of women alcoholics corroborate these clinical findings (Curlee 1970; Kinsey 1966; Wilsnack 1973).

Considerable attention has been paid in the literature to the relationship between obstetrical-gynecological phenomena and the effects of alcohol upon women (Belfer et al. 1971; Dubowski 1976; Jones and Jones 1976a, 1976b; Lolli 1953; Podolsky 1963). Discussions range from differ-

ing blood alcohol levels at various phases of the menstrual cycle to the relationship between premenstrual tensions and alcoholic drinking.

Information regarding whether gynecological and obstetrical difficulties preceded as well as followed problem drinking was not a topic for discussion at the conference. Many of the programs gather such information through medical histories, but the focus of program directors at the Minneapolis meeting was on treatment needs of clients vis-a-vis the high rate of gynecological problems in evidence.

Holistic treatment of the female alcoholic suggests looking at all factors associated with a woman's problem drinking. Biological events of menstruation, menopause, pregnancies, miscarriages, abortions, or infertility are attended to during the recovery process only insofar as they appear problematic for the client while in treatment. While there is no intent to minimize the importance of any factor that may be associated with alcoholic drinking, there is also no apparent need felt by these programs to single out particular biological events as being precipitous of a client's alcoholism problem. Instead, each event seems to have importance as a means of understanding the overall schema of treatment needs—for example, how menstrual stress or menopause fits into a woman's sociopsychological life situation. Medical researchers could contribute to rehabilitation programming by supplying data and information about medical consequences of heavy drinking for women in different age groups, women who combine alcohol and drugs, and other factors.

**Psychological features.** Without intending to be scornful of the time and effort spent by researchers on depression as a significant factor of alcoholism in women (Jones 1971; Schuckit 1972; Schuckit et al. 1969; Winokur and Clayton 1968), program staff consider depression to be so symptomatic of alcoholism as to render the large amount of research attention to this concept meaningless.

Depression is an accepted fact of alcoholism for both men and women. A distinction between alcoholic de-

pression and clinical or psychiatric depression was made by all of the programs represented at the conference. Most of the female clients in these facilities are clinically evaluated as being alcoholic with *accompanying* depressive symptoms. Clinical experiences indicate that as the women become sober, depression diminishes. However, if a client's depression continues after successful completion of treatment or if symptoms of depression reappear later on in recovery, the treatment staff will refer the client to other professionals for assistance.

Until recently, women clients in treatment were predominantly characterized as being alcoholically depressed. Changes in deinstitutionalization statutes, however, have created an increase in client populations at these agencies of women with primary psychiatric problems and secondary alcoholism.

While the topic of depression as a treatment issue received little attention at the Minneapolis conference, issues of self-esteem and self-concept were seen as crucial to the understanding and treatment of women's alcoholism. Low self-esteem, poor self-concept, and dependency are overriding characteristics of women in treatment, according to conference participants. Research on women alcoholics suggests that a central feature of female alcoholism is not dependency, but rather a preoccupation with femininity and overevaluation of the wife-mother role (Kinsey 1966; Wilsnack 1972, 1973). Or, as Gomberg (1974) advised, "the alcoholic woman may be . . . conflicted and ambivalent about being a woman, she still protests her femininity while the more assertive, aggressive aspects of her personality are denied, just below the surface" (p. 176).

Measurements of conscious and unconscious femininity are rarely sought by alcoholism counselors. However, the manifestations of poor psychosocial adjustment, low self-esteem, and feelings of inadequacy that characterize the women in treatment are clearly documented in clinical records. Whether these characteristics reflect sex-role conflict, unsuccessful





struggles to overcome rigid, self-deprecating attributes of traditional femininity, or a basic lack of confidence and self-worth is still unknown. A description of the female alcoholic found in the literature (Blane 1968) that supports clinical evaluations states that "the central, perhaps inevitable, feature in women with alcohol problems is a concern, even a preoccupation about being inadequate and inept, surrounded by an aura of futility that bespeaks her utter helplessness to change herself" (p. 112).

Lacking the confidence to have a positive self-identity, alcoholic women seen in treatment develop a self-image based upon relationships with others, particularly sexual relationships. Dependency upon these relationships is paramount for the woman who feels worthless and is guilt ridden about her own inadequacies.

Learned helplessness, passivity, and dependence upon others are characteristics of the traditional female sex role and of the alcoholic women seen in these treatment programs. Recovery from alcoholism, according to the conference participants, is correlated with developing a healthy balance of independence and dependence, learning skills to become self-reliant, assuming responsibility for self, and developing a comfortable, albeit new, identity as women.

When examining how alcoholic women see themselves as compared with nonalcoholic women, McLachlan and associates (1979) found, in a controlled study of 100 female alcoholics and 100 nonalcoholic women, the alcoholic women saw themselves as less effective in goal achievement, less socially competent, and more anxious than the controls. According to the experiences of the program directors, the dependency, self-esteem, and sex role issues observed in their clientele are similar to, but extreme forms of, sex role struggles of women in general.

**Employment.** Alcohol problems of women in the workplace have received some attention in the literature within the past few years, yet little is known about alcoholism and the working woman. One study suggests that em-

ployment may be a favorable prognostic factor in the recovery of alcoholic woman. From a sample of 136 women alcoholics, Bateman and Petersen (1972) found that females who were employed at the time of entering treatment had a higher rate of abstinence than those who were not employed. In another study, Schuckit and Morrissey (1976) found that women with lower status jobs remained abstinent for a longer period of time than did women employed in higher status occupations.

Six occupational alcoholism programs were represented at the Minneapolis conference, but the relationship of employment status to successful outcome was not a topic under discussion. Instead, these participants focused on the differing rates of identification of problems between men and women in occupational programs. Findings based upon experiential and empirical data gathered by these programs suggest that women's alcohol problems remain hidden in the workplace (Gomberg 1977). Reasons given by these participants to explain the lower rate of identification and referral of women with alcohol problems are that (1) women are more expendable to the organization than are the male employees; (2) stigma associated with alcoholism in women creates an aura of protectiveness toward the female problem drinker; and (3) supervisors find it difficult to discuss potential alcohol problems with female employees. The finding that married women working outside the home report higher rates of heavy or problem drinking than do housewives suggests that research is needed to learn more about drinking behaviors and problems of women in the workplace.

**Stigma.** Barriers to reaching and treating women alcoholics are well documented in the literature (Beckman 1975; Blume 1978; Curlee 1967; Gomberg 1974; Lindbeck 1972; Marden and Kolodner 1980; Sandmaier 1978). The most often cited barrier to helping the female alcoholic is the stigma that results from a moral definition of alcoholism and the double standard toward women who are intoxicated

and alcoholic that serves to keep alcoholic women hidden.

National media campaigns, community education series, and personal testimonies have been forceful attempts to increase public awareness regarding the magnitude and scope of alcohol problems among women. But how effective have these efforts been in reducing the stigma associated with alcoholism in women? In some conservative rural areas, program personnel at the conference spoke of living in a time vacuum where alcoholism, male or female, is still considered a sign of moral corruption. Ethnic and religious groups continue to resist messages from "outsiders" about the alcohol problems of their people. And in some situations heightened awareness leads to public acknowledgement for the need for services, but lingering stigma coupled with fiscal limitations restrict services for alcoholic women.

Aware of the barriers to getting women into treatment, 45 federally funded programs pioneered to break through cultural, social, and economic resistance to provide treatment to alcoholic women. Although the literature on alcoholism and women may have prepared program staff for the difficulties they would encounter getting women into their treatment facilities, few of the program directors were cognizant of the ways in which stigma would affect the development and growth of their centers. From the accounts of the conference participants in Minneapolis, it seems that stigma attached to alcoholism in women is complicated by stigma against professional women providing services to alcoholic women. Yet to be documented in the literature are the effects of resistance from community groups to the establishment of women's alcoholism programs administered by a totally or predominantly female staff. As a result of the historical accounts of these programs, future research may wish to take a holistic approach to the consequences of stigma directed toward both client and helper, and using systems theory, investigate the relationship between stigmatizing factors and women's alcoholism service delivery.





## Issues Related to Treatment of Women

**L**ow representation of women in treatment centers, comparisons of male and female alcoholics using traditional measurements developed for male clients, and unrecognized differences in the recovery needs of men and women alcoholics have produced an inconclusive picture of the treatment needs of women. From the existing alcoholism literature, it can be surmised that female alcoholics have more psychopathology than do their male counterparts (Johnson 1965; Jones 1971; Karpman 1948), have poorer prognosis (Bateman and Peterson 1972; Dudko and Kochev 1971; Glatt 1961), prefer individualized attention in treatment (Curlee 1971; Lindbeck 1975), and suffer with low self-esteem (Jones 1971; McLachlan et al. 1976), heightened feelings of guilt (Babcock and Connor 1981; Gombert 1974; Sandmaier 1976), and sex-role conflict (Kinsey 1966; Wilsnack 1972, 1973).

Women's treatment programs characterize the female alcoholic somewhat differently. First of all, there is less tendency to make comparisons between male and female alcoholics and more focus on learning about the specific treatment needs of women. To accomplish this end, it became necessary for the programs to develop diagnostic techniques that addressed the multiple needs of the women seeking treatment. By so doing, these programs have moved away from conventional assessments focusing primarily on drinking behavior that had been originally designed for and used with male alcoholics.

In developing a treatment philosophy focused on women, these programs turned to a holistic model of treatment as a means of identifying clients' problems. In this schema, alcoholism treatment is understood vis-a-vis clients' roles and status as women, with alcoholism seen as one component of a client's total life experience.

Following a holistic model of alco-

holism treatment, women alcoholics are seen as having identifiable gender needs that must be addressed in recovery. Agreeing with descriptions of women alcoholics found in the literature, the conference participants spoke of female clients as having low self-esteem, feelings of inadequacy, poor self-concept, and extreme guilt. Companion features to the expressed treatment needs are issues of dependency and exaggerated reliance on relationships with others for self-identity.

Comparing the psychopathology of men and women alcoholics is beyond the mission and interest of the women's programs and, therefore, not a topic for serious consideration. However, prognosis and outcome variables of clients in women-focused treatment programs are extremely important to the conference participants. Some of the programs have developed elaborate mechanisms for measuring outcome, but others have not had the finances to conduct followup and evaluative studies. "The quality of research evidence on the progress of the female alcoholic in treatment has contributed to the development of a sizable body of myth and speculation," according to Emrick (1975). Yet the experiences of the participants at the Minneapolis conference indicate that women alcoholics treated in programs using a holistic model of alcoholism recovery have a comparably high rate of treatment success. Representatives at the conference were strongly in favor of empirically testing their experiential findings. Furthermore, according to the participants, until we have learned about the effectiveness of alcoholism treatment that addresses women's needs, it is premature to make comparisons between treatment outcomes of male and of female alcoholics.

It was clear that outreach strategies, treatment needs, and aftercare planning vary within subpopulations of alcoholic women. Conference partici-

pants took the position that alcoholic women have certain generalized needs. Though varying in degree or intensity, these needs must be addressed during the recovery process. Because there is so little research information on the relationship between the factors listed below and successful outcome for women alcoholics, program staff continue to depend upon their experiences and perceptions of the importance of these issues to the successful treatment of alcoholic women.

**Role modeling.** Because role modeling is seen as an extremely important factor in women's treatment, almost all of these programs were strongly in favor of single sex therapy groups and a predominance of female staff. Statements have been made in the literature that the sex of the therapist is an important prognostic factor of the treatment outcome of women (Birchmore and Walderman 1975; Calobrisi 1976). But with the exception of one empirical study to support this idea (Ruggels et al. 1977), the supposition that outcome results for female alcoholics may be superior with female therapists remains untested (Annis and Liban 1980).

**Dependency.** Alcoholic women have difficulty seeing themselves as separate, autonomous individuals and instead develop identities based entirely upon their relationships with others. Dependent dyads must be examined during recovery, particularly how the alcoholic woman relates to her sexual partner. However, dependency issues are also evident with parents, families, friends, food, and so forth.

In keeping with dependency needs, alcoholic women coming into treatment prefer one-to-one relationships with counselors. Once introduced to group therapy, however, clients are very accepting of the group process and do well in this treatment modality. Because relationships are so important to the alcoholic woman, treatment





planning must be designed to include all significant persons in the life of the alcoholic woman.

It has been suggested (Curlee 1967; Lindbeck 1975) that individual therapy may be more applicable to women's treatment needs than group therapy. Even though it is widely accepted that no single modality will be efficacious for all alcoholic women, to date there is very little empirical information that analyzes the relationship of therapeutic modality to treatment outcome for women (Annis and Liban 1980).

**Sexism and sexuality.** Treatment staff and clients alike have been socialized to have stereotypic attitudes and expectations of women, of women alcoholics, and of homosexuals. The experiences of these programs indicate that alcoholism treatment for women is enhanced when clients and staff become aware of their own attitudes and beliefs that act as encumbrances to recovery.

The American Psychological Association's Task Force on Sex Bias and Sex-Role Stereotyping (1978) pointed to the need to eliminate biases in the process of therapy. Hare-Mustin

(1978) warned male and female therapists about the subtle, often unconscious, patterns of behavior that act to humiliate and debase women in treatment.

**Children of female alcoholics.** There seemed to be a lack of agreement among program participants as to whether having child care as a component of alcoholism treatment enhances or hinders a woman's recovery. Two of the programs, one serving white women and the other treating black alcoholic women, firmly believe that without child care facilities their clients would not enter treatment. Furthermore, learning about effective parenting is important to alcoholic women with children and, in the opinion of these programs, occurs more naturally when women and children are residing in the same setting. Other program participants at the conference have found that alcoholic mothers need some distancing from their children in order to be able to focus on their primary needs in alcoholism treatment. In any case, all the program participants agreed that the children of alcoholic mothers have their own treatment needs resulting

from growing up in an alcoholic family.

To date, there are no empirical data available that compare the outcome of alcoholic women who experience treatment conjointly with their children with women who enter treatment without their children.

**Therapeutic modalities.** Various forms of therapy are used by women's alcoholism treatment programs including reality, Gestalt, and Jungian therapies; behavior modification; and didactic, experiential, and peer counseling. Empirical data are unavailable regarding the relationship of treatment outcome and specific therapeutic approaches. The experiences of the programs suggest that successful outcome may be more closely related to individual client strengths and to the therapist's attitudes than to a specific therapeutic modality. Writing about treatment effectiveness, Gomberg (1974) gave her opinion that "the assets of the patient and the concern of the therapist are . . . the major determinants of effectiveness, not the treatment modality used" (p. 183).

## Future Directions For Research

The conference participants raised a number of questions that will require further research.

Questions related to casefinding included the following:

- What is the relationship of selected outreach strategies to client response and client outcome?
- What impact do specific outreach strategies have on the needs of various subgroups of women alcoholics, such as blacks, Hispanics, lesbians, rural or urban residents, the elderly, women in the home, and women of different income levels?
- Are outreach activities more effective when conducted by one staff per-

son or when the entire staff is responsible for a program's outreach component?

- Given cultural mores of male protectiveness that keep Hispanic women out of treatment, is a male Hispanic staff member preferable for outreach in Latin communities?
- Are women more apt to enter treatment in times of crisis than at other times?

The following questions were raised relating to treatment issues.

- Do women alcoholics have a higher success rate when their counselors are female?
- Are successful outcome rates higher for women alcoholics in women's pro-

grams than for those who receive treatment in coed programs?

- Are single-sex therapy groups superior to mixed-sex groups throughout the treatment process?
- Are holistic alcoholism treatment programs more effective than conventional programs for alcoholic women?
- What are the most effective ways to help a woman alcoholic in treatment learn to balance attributes of dependence and independence?
- What are the treatment needs of the children of an alcoholic parent?
- Is treatment for an alcoholic mother more effective when the children reside in the treatment center with her or when she enters treatment without the





children?

- Are homogeneous or heterogeneous treatment groups more effective for alcoholic women?
- Do the treatment needs of polyaddicted women differ from those of women who are addicted only to alcohol?
- Do women alcoholics fare better in treatment when their families are involved in the treatment process?
- Are specific treatment techniques more effective with certain groups of alcoholic women? How can this be measured?

Aftercare issues were also addressed by the conference participants. The following questions were raised.

- Is the effectiveness of an aftercare program directly related to a program's ability to assess women's needs during treatment?
- Should the structure of aftercare programs in outpatient and residential programs be similar or different?
- What are the most effective aftercare and followup strategies for various subpopulations of women?
- How is the issue of grief most effectively handled in treatment and in aftercare?
- What is the most effective length of

time for an alcoholic woman to remain in aftercare? Does the time requirement vary for subpopulations of alcoholic women?

Questions related to the treatment of female subpopulations included the following:

- What strategies are effective in attracting and holding black women in treatment for alcoholism?
- Can programs treating predominantly white women successfully reach and treat black alcoholic women?
- Are there specific outreach and treatment strategies that are effective for lesbian alcoholics?
- What is the incidence of alcoholism among middle-class black women?
- Do elderly alcoholic women in treatment have higher success rates than do younger women?
- What are effective ways to reach and to keep Hispanic women in treatment?
- What is the incidence of fetal alcohol syndrome in Native American children?
- How can the high rate of cirrhosis in alcoholic Native American women be explained?
- Is the success rate for Native American women treated in culturally speci-

fic programs higher than for those treated in other programs?

- Do incarcerated alcoholic women have special treatment needs?
- Should different techniques be used by occupational programs to identify men and women alcoholics?
- What methods are effective in identifying and referring working women with alcohol problems?
- Is the single career woman different from the married working woman in terms of drinking behavior and outreach needs?
- Is the employee assistance program model better suited for single career women than for married working women trying to hold dual careers at home and in the workplace?

Finally, several general questions were posed:

- What is the most effective way to break through a community's denial of women's alcohol problems?
- How will the changes in funding structure affect alcoholism services that focus on women?
- Is Alcoholics Anonymous culturally relevant to minority groups and to women?

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